MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: EXAMINING PHYSICIAN EFFORTS TO PREPARE FOR MEDICARE PAYMENT REFORMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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C O N T E N T S

WITNESSES

SUBMITTED MATERIAL

MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT OF 2015: EXAMINING PHYSICIAN EFFORTS TO PREPARE FOR MEDICARE PAYMENT REFORMS

TUESDAY, APRIL 19, 2016

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:14 a.m., in room 2322 Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Guthrie, Shimkus, Burgess, Bilirakis, Long, Ellmers, Bucshon, Brooks, Green, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cárdenas, and Pallone (ex officio).

Staff present: Gary Andres, Staff Director; Rebecca Card, Assistant Press Secretary; James Paluskiewicz, Professional Staff Member, Health; Graham Pittman, Legislative Clerk; Jennifer Sherman, Press Secretary; Heidi Stirrup, Policy Coordinator, Health; Kyle Fischer, Democratic Health Fellow; Tiffany Guarascio, Democratic Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Democratic Policy Analyst; Andrew Souvall, Democratic Director of Communications, Outreach, and Member Services; and Arielle Woronoff, Democratic Health Counsel.

Mr. PITTS. The time of 10:15 having arrived, the subcommittee will come to order. The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Today's hearing is a sequel to our Health Subcommittee's earlier review of the implementation progress of the Medicare payment reforms as included in the Medicare Access and CHIP Reauthorization Act of 2015—MACRA—which repealed the sustainable growth rate and replaced it with new payment models and other reforms.

Through a variety of incentives, MACRA encourages physicians to engage in activities to improve quality, patient experience and outcomes and reduce costs.

Prior to MACRA, physicians not only faced the threat of unsustainable cuts from the SGR, but a series of well-meaning but

uncoordinated requirements stacked on top of each other from a variety of reporting requirements.

MACRA seeks to consolidate, streamline and integrate these efforts into a single program. However, rather than wait until CMS issues a proposed rule on how they plan to implement these incentives and program changes, there are steps every practitioner can be taking right now.

Physicians should be thinking about ways they can modernize their practices and participate in current programs to act as a springboard for their preparation for MACRA.

Provider organizations should be developing measures to aid their members and help MACRA's goal of creating meaningful measurements that every provider feels are relevant to them.

Physicians should also start evaluating options available to them, whether the Merit-based Incentive Payment System—MIPS—or the Alternative Payment Methods—APMs—is right for them both for tomorrow and where they want to direct their practice in the future.

Our hearing today will examine options for ensuring the smoothest transition for our providers, based on what we know today. We expect to hear today from our witnesses who come from diverse backgrounds and training and practice from all over the country in rural and urban settings.

Each are practicing physicians in different arrangements and all have worked with their organizations to provide tools and best practices that other physicians can utilize and learn from to be better positioned to succeed under MACRA.

By the conclusion of today's hearing, our Health Subcommittee will have held two oversight hearings on the implementation of MACRA prior to the issuance of CMS' proposed rule.

As we have demonstrated in our commitment so far, the Energy and Commerce Committee will continue to be vigilant in our bipartisan oversight to ensure MACRA is a success and this will certainly not be our last hearing on the matter.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Today's hearing is a sequel to our Health Subcommittee's earlier review of the implementation progress of the Medicare payment reforms as included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) which repealed the Sustained Growth Rate (SGR) and replaced it with new payment models and other reforms.

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Mr. PITTS. My time is expired. I now yield to the ranking member, Mr. Green, 5 minutes for his opening statement.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman, and I thank our witnesses for being here today and I want to thank you for this—the hearing, the second part of our subcommittee's hearing on the implementation of MACRA.

As we know, the Medicare Access and CHIP Reauthorization Act, or MACRA, was signed into law a little over 1 year ago. This landmark legislation repealed the flawed sustainable growth rate, the SGR, formulated to provide long-term stability to the Medicare physician fee schedule and reward value over volume.

It was critically important that Congress pass and the CMS institute a reasonable responsible payment policy for physicians and Incentivize quality care that spends our dollars wisely.

Now that the historic achievement of finally repealing and replacing the SGR has been made, staunch oversight over the implementation of MACRA is critical.

This will ensure that we do not make the same mistakes of the past. To do so, we need a system that's set up that's fair, smart and sophisticated enough to meet the unique challenges of a variety of providers participating in the Medicare system and their patients.

The physician stakeholder community provided extensive feedback during the development of MACRA and publicly supported and voted the bill through the passage into law.

Like all of us, the provider community appreciates this important step toward a more rational payment system and share a sense of ownership over it.

I want to thank the stakeholders who continue to work with this subcommittee and CMS to ensure that the legislation works for the spectrum of providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is consistent with the broader mission that Congress and the administration have engaged in over the last decade beginning with the Affordable Care Act.

As we know, MACRA provides stable updates for 5 years and ensures no changes are made to the current payment system for 4

years. In 2018 it establishes a streamlined improvement incentive payment program that will focus the fee for service system on providing quality and value.

The incentive payment program refer erred to as Merit-based Incentive Payment System, or MIPS, consolidates the three existing incentive programs continuing to focus on quality, resource use and a meaningful electronic health record use.

But unlike the past, it does this in a cohesive program that avoids redundancies. MACRA also provides another route to incentivize the movement away from volume-based payments by giving financial bonuses to providers who participate in alternative payment models, or APMs.

APMs hold great promise but their viability and effectiveness requires sophisticated construction and implementation.

I look forward to hearing from our witnesses about their vision for the APMs, specifically how the model will be designed so that they are relevant to different specialties, different sizes of practice and in line with State-based initiatives and private insurance models.

APM should prioritize measures on outcome, patient experience, care coordination and measures of appropriate use of services. They should also take into account gaps in quality measurements and applicability of such measures across the various healthcare settings.

It is the intent of Congress that specific quality metrics used will be tailored to different provider specialties and each eligible professional will receive a composite quality score.

The challenges with constructing a system that fully accounts for the variabilities in providers and the type of care they're trained to provide and the patient mix as well as how to meaningfully evaluate quality are significant.

But I believe it can be accomplished. To do so, the Centers for Medicare and Medicaid, CMS, has initiated a rule making process. A rule is imminent. I know everyone in this room is looking forward to its release by CMS.

When the rule is announced I'm confident we'll see additional stakeholder engagement, collaboration, continuation of the transparent and public process throughout the course of implementation.

MIPs and the opportunity to participate in APMs is just around the corner. Now it's time to start preparing. I look forward to hearing from our panel on how they're instructing their peers to begin to prepare for transition.

This subcommittee will continue to exercise oversight over MACRA implementation, not just today but throughout the rule making process.

And again, Mr. Chairman, I thank you for calling the hearing and a follow-up and I hope we'll have other ones as we go along. Again, we don't want to repeat the problems of 1997.

I yield back.

Mr. PITTS. The Chair thanks the gentleman. Now, filling in for the chair of the committee, Dr. Burgess, 5 minutes for opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman, and thank you, Ranking Member Green, for reminding me why I wake up in a cold sweat at 4:00 o'clock every morning. The word is that the next part of this act does not go as well as the first part.

But last week we had the 1-year anniversary of the passage of H.R. 2. Big deal. And this—now we're all reflecting on the historic accomplishment of permanently and forever repealing the sustainable growth rate formula. And just take—worthwhile to take a moment to acknowledge.

It could not have come to pass without the commitment of the medical community and the leadership of the Energy and Commerce Committee on both sides of the dais.

The hard work is far from over, however, and we've entered into what I like to consider a 5-year cessation of hostilities between the Congress, the agency, and doctors, and we need to make certain, as Ranking Member Green pointed out, that we get it right during this interval.

So we are now having our second hearing on the implementation phase of the Medicare Access and CHIP Reauthorization Act and I'm glad that this committee does remain dedicated to ensuring that we get this next phase of payment reform right.

In the act, we sought to put power back in the hands of those who actually provide the care so the doctors, not agencies, will help shape Government care payments systems of the future.

And I am encouraged that when CMS began the process of implementation of this reform it began with a request for information and I was even more encouraged by the response from doctors.

We had 560-odd responses to that request for information. It is important to note that doctors actively engaging in the regulatory process can't just be at the beginning.

We've got to see this through, and certainly the societies have some obligation to help doctors actually prepare for the implementation of this.

Medicare participation should never subject doctors to the things that we've—we want our doctors to take care of our Medicare patients.

Some would argue that Congress shouldn't even be in the business but we are and we've been there for 50 years. We might as well do it right if we're going to do it and part of doing it right is we shouldn't punish doctors.

But right now, doctors have to do this—all of these different quality incentive programs. The piecemeal initiatives have undermined their ability to focus on quality.

So to resolve that problem, the MACRA requires CMS—all these acronyms—MACRA requires CMS to streamline the current programs into a single value-based payment structure.

This is called the Merit-based Incentive Payment System and the system is designed to incentivize quality whether a doctor is an independent in rural practice or in a large integrated healthcare system, and that was an extremely important part of just getting H.R. 2 done.

We had to allow for success in whatever practice or arrangement a doctor was in. We had to meet them where they were.

Now, this transition is not going to happen overnight and I am certain that—what I am certain of right now is that no doctor is going to face the double digit cuts that they were facing under the SGR. But really, truly, we don't want our doctors to wait until 2019 to begin to take action.

Congress currently is universally condemned for being dysfunctional, ineffective. Not a headline there to the guys writing for the press. I know that.

But when you stop and think about what we accomplished with the overwhelmingly bipartisan passage of H.R. 2, and I would note I went to all the celebratory things down at the White House where the president took credit for it. But, honestly, it wasn't the president's deal. It was the committee's deal and we brought the other committees of jurisdiction, both the House and Senate, along with us and it was truly that bipartisan effort.

Henry Waxman was my co-sponsor on H.R. 2. I mean, that's phenomenal in and of itself when you think of it.

But it isn't just—and when you look at some of the successes and failures of major healthcare policy that have come through Congress in the past it's also—you know, they always say the devil's in the details.

So this is where the devil's in the details and we've got to get this—we've got to get this right.

It took two decades to replace the SGR because it was hard to do and it required a certain commitment and a certain suspension of hostilities between Republicans and Democrats on the dais. But we did it because it was the right thing to do, and we're going to be called upon to do that again in the future.

I don't know what form that will take but in other healthcare policy that certainly we could—people would do well to follow the template that we provided in the Energy and Commerce Committee.

The policies outlined in H.R. 2 are the result of an open and transparent process which sought input and participation from every doctor, patient, member of Congress, administrative agency and anyone else who professed an interest.

We're at this critical juncture in physician payment reform and we'll only get it right if implementation follows that same open, transparent and bipartisan structure that we use to get this to the president's desk.

I want to thank all of our witnesses for being here today. I sincerely appreciate the efforts of all of the provider groups to help us in going forward.

I look forward to your testimony today and look forward to the next in what will be a series of hearings, Mr. Chairman. I'll yield back.

Mr. PITTS. The Chair thanks the gentleman.

The ranking member wants to say something.

Mr. GREEN. Chairman, I just want to thank my colleague from north Texas. But, you know, I felt the same way about the President because he got the Affordable Care Act called Obamacare and

all he had to do is sign his name to it. We had to do the legwork. So I understand how you feel.

Mr. BURGESS. Some of us did not do that legwork, nor did we vote for it, nor will we ever, Mr. Green. So if you want me to refer to that as Greencare in the future, I'll be glad to do that.

Mr. GREEN. All right.

Mr. BURGESS. I will be honored to do that because I said that.

Mr. PITTS. OK. The Chair now recognizes the ranking member of the full committee, Mr. Pallone, 5 minutes for opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

I think this is an important hearing and I thank the witnesses for being here today.

We're meeting to continue our discussion on one of the great bipartisan success stories of this committee, the Medicare Access and CHIP Reauthorization Act, or MACRA.

Our panel of witnesses practice in a variety of settings across the country and represent diverse expertise and training. They each have the unique perspective to share with us regarding the implementation of MACRA.

The law put in place a dual track system for providers instead of the patchwork of quality reporting systems that providers currently use. They will instead use the Merit-based Incentive Payment System, or MIPS, and MIPS will streamline quality reporting for providers and incentivize high-quality efficient care.

Providers are most enthused to use alternative payment models, or APMs, which have also proven to increase quality and lower costs.

Today we'll discuss the steps all providers can take to modernize their practices, provide higher quality care for their patients and successfully transition to the new payment models established by MACRA, and this will be our second hearing on MACRA implementation. I'm pleased this committee is performing such thoughtful oversight.

While we know that MACRA is already showing promising results, these hearings are necessary to ensure that the law reaches its full potential and I look forward to discussing the tools and best practices physicians can employ to help make MACRA work effectively for all.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Good morning. Thank you, Mr. Chairman, for holding this important hearing, and thank you to the witnesses for being here today.

We're meeting to continue our discussion on one of the great bipartisan success stories of this committee, the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. Our panel of witnesses practice in a variety of settings across the country and represent diverse expertise and training. They each have a unique perspective to share with us regarding the implementation of MACRA.

The law put in place a dual track system for providers. Instead of the patchwork of quality reporting systems that providers currently use, they will instead use the

Merit-Based Incentive Payment System or MIPS. MIPS will streamline quality reporting for providers and incentivize high-quality efficient care. Providers can also choose to use Alternative Payment Models or A–P-Ms, which have proven to increase quality and lower costs.

Today we will discuss the steps all providers can take to modernize their practices, provide higher quality care for their patients, and successfully transition to the new payment models established by MACRA.

This will be our second hearing on MACRA implementation and I'm pleased that this committee is performing such thoughtful oversight. While we know that MACRA is already showing promising results, these hearings are necessary to ensure that the law reaches its full potential. I look forward to discussing the tools and best practices physicians can employ to help make MACRA work effectively for all. Thank you.

Mr. PALLONE. So I just want to yield the remainder of my time to Congresswoman Matsui from California.

Ms. MATSUI. Thank you for yielding.

Thank you, Mr. Chairman, for holding this second hearing on MACRA. Last year, we joined together in overhauling the broken SGR system, replacing it with one that incentivizes quality over quantity of care, rewards efficiency and encourages the use of breakthrough technologies that will provide more people access to health care across this country.

I am looking forward to discussing ways we can advance the transitions that are already happening and will accelerate with MACRA.

Today, we are joined by physicians who offer important perspectives and best practices for ensuring that delivery systems continue to make inroads in providing high-quality efficient health care to patients.

One of the ways I believe that we can expand access to care and improve outcomes is through the incorporation of telemedicine and to this new value-based system.

Through telemedicine we truly have the opportunity to better engage patients and their families, improve care coordination with loved ones and maximize efficiency of resources.

As we make inroads into this health system transformation, I look forward to working with you and hearing your perspectives on these important issues. Thank you and I yield back.

Mr. PITTS. The Chair thanks the gentlelady. As usual, all the members' written opening statements will be made a part of the record. I'd like to submit the following documents for the record: statements from the American College of Cardiology, the American College of Surgeons, the Alliance of Specialty Medicine, the American Society of Clinical Oncology, the Advanced Practice Registered Nursing Organizations, the Infectious Diseases Society of America, and comments and a statement from the Medical Group Management Association.

Without objection, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. PITTS. We have one panel today. I'll introduce them in the order of their presentations.

First, Dr. Robert McLean, MD, FACP member of the Board of Regents, chair of the Medical Practice in Quality Committee, American College of Physicians; then Dr. Robert Wergin, MD, FAAFP, board chair of the American Academy of Family Physicians; Dr. Barbara McAneny, MD, immediate past chair of the American

Medical Association, and finally, Dr. Jeffery Bailet, MD, MSPH, FACS, executive vice president of the Aurora Health Care, co-president of the Aurora Health Care Medical Group.

Thank you for coming today. Your written testimony will be made a part of the record. You'll be each given 5 minutes to summarize your testimony.

And so we'll begin by recognizing Dr. McLean for 5 minutes for his summary.

STATEMENTS OF ROBERT MCLEAN, M.D., MEMBER, BOARD OF REGENTS, AND CHAIR, MEDICAL PRACTICE AND QUALITY COMMITTEE, AMERICAN COLLEGE OF PHYSICIANS; ROBERT WERGIN, M.D., BOARD CHAIR, AMERICAN ACADEMY OF FAMILY PHYSICIANS; BARBARA L. MCANENY, M.D., IMMEDIATE PAST CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; JEFFREY BAILET, M.D., CO–PRESIDENT, AURORA HEALTH CARE MEDICAL GROUP

STATEMENT OF ROBERT MCLEAN

Dr. MCLEAN. Thank you.

My name is Robert McLean. I am pleased to share with you the perspectives of the American College of Physicians on the key issues we believe should be addressed in the implementation of MACRA and what we are doing to prepare our members to be successful under it.

On behalf of the college, I wish to express our appreciation to Chairman Pitts and Ranking Member Green for convening this hearing.

I'm a member of the college's Board of Regents and chair of its medical practice and quality committee. ACP is the Nation's largest medical specialty organization representing 143,000 internal medicine physicians and medical student members.

In addition to teaching medical students, residents and fellows Yale, I'm also a full time practicing physician who sees over 80 patients per week as part of the Northeast Medical Group of the Yale New Haven health system.

We sometimes forget even though it has been only a year what has been achieved by repealing the SGR and replacing it with MACRA.

For years, many looking to improve our healthcare system have embraced the laudatory goals of the triple aim—improve the patient experience of care, improve the health of populations and reduce per capita healthcare costs.

However, when I would mention this to my colleagues in practice I frequently received glazed looks and given their list of real world concerns such as I'm struggling with my electronic health record—I am overwhelmed with these regulations—I'm given data on clinical metrics and do not know what to do with it—my patients are unhappy because I am taking visit time away from them to deal with all of these hassles, and before MACRA repealed the SGR, they would then add and I have to worry every year that my Medicare fees will be cut up to 20 percent or more due to some crazy formula. In that environment, can anyone wonder why there is such concern about physician burnout?

Since MACRA became law, though, I can truly tell my colleagues that there is reason for hope. I tell them that the MACRA law will align and simplify some of the measures and reporting. It will truly reward those who have made investments in advanced practice structures like the patient-centered medical homes and will eliminate the yearly financial anxiety created by the dreaded SGR. Then those glazed and frustrated looks change dramatically.

With surprise, I'm then asked, you mean that this law really does things that will simplify our lives and practice and allow us to focus more on delivering high-quality care to our patients, and I tell them yes.

One way that MACRA does this is by giving physicians more control over our Medicare payments. As you're aware, the SGR resulted in ever physician's conversion factor being cut by the same scheduled amount no matter how cost effective they were or the quality of care they provided the patients.

MACRA fundamentally changes this because the annual adjustment in each physician's conversion factor starting in 2019 will be based on each physician's own contribution to improving quality and providing care more effectively, giving physicians more control over their annual payments while benefitting patients with better outcomes. I truly believe that MACRA can be a shot in the arm to combat burnout if it is rolled out as Congress intended.

To this end, the college has provided CMS with our views on the priorities it must address as MACRA is implemented. There are three in particular that I'd like to highlight.

Number one, CMS must improve the measures to be used in the quality performance category of MIPS and established less burdensome reporting as Congress clearly intended when it harmonized existing Medicare quality reporting programs into MIPS.

Number two, ACP is very pleased that MACRA supports patient-centered medical homes through both the MIPS program and as an alternative payment model and has urged CMS to create multiple realistic ways for medical homes to obtain certification.

We are encouraged by CMS' announcement just last week of the Comprehensive Primary Care Plus program, a multipayer patient-centered medical home initiative which potentially could enable participating practices to qualify for higher payments under MACRA.

And number three, CMS should promote innovation by employing a very broad definition of entities that should be considered eligible APMs as well as create pathways for multiple physician-focused APMs to be accepted.

It isn't just up to CMS to ensure that MACRA is implemented successfully. Professional associations including the ACP must do our part. Our educational efforts include online resources, guides, presentations, articles in our publications and practical tools, all designed to help our members prepare for MACRA. This includes MACRA-specific sessions at our annual scientific meeting to be held here in Washington, DC, just two weeks from now.

One thing I would like to highlight is the ACP practice advisor, an online interactive tool that offers practices the ability to conduct significant evidence-based quality improvement based on the most up to date clinical guidelines, improve performance on clinical qual-

ity measures, implement the principles in the medical home model and improve the overall management of their practice.

While the practice advisor serves to facilitate practice transformation independent of any given payment model, it is particularly relevant to preparing physicians to be successful under MACRA.

Thank you for giving the ACP the opportunity today to share our perspective on what CMS needs to do to ensure that MACRA is implemented as Congress intended and on what we are doing to help our members be prepared to succeed under this landmark law.

Thank you.

[The prepared statement of Dr. McLean follows:]

Statement for the Record

American College of Physicians

Hearing before the Energy and Commerce Health Subcommittee

On

Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

April 19, 2016

My name is Robert McLean. I represent the American College of Physicians (ACP), the nation's largest medical specialty organization, representing 143,000 internal medicine physicians who specialize in primary and comprehensive care of adolescents and adults, internal medicine subspecialists, and medical students who are considering a career in internal medicine. I am a member of ACP's Board of Regents and Chair of its Medical Practice and Quality Committee. I am a practicing physician in New Haven, CT who sees over 80 patients per week, am board certified in internal medicine and rheumatology, and am an Associate Clinical Professor of Medicine at the Yale School of Medicine. I am part of a multi-specialty group that, in recent years, aligned with a larger network, now called the Northeast Medical Group of the Yale New Haven Health System. Today, I am pleased to share with you the College's perspective on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), a law that not only repealed the flawed Medicare Sustainable Growth Rate (SGR), but one that of equal importance, creates pathways for physicians to transition to payment and delivery systems aligned with the value of care that we provide to our patients.

On behalf of the College, I want to express our appreciation to Chairman Pitts and Ranking Member Green for convening this hearing and for your shared commitment in wanting to ensure that the payment and delivery system reforms created under MACRA are implemented successfully and as

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intended by Congress. We also appreciate the Committee inviting input from the physician community during the implementation process.

Enactment of MACRA represented the rare situation where physicians, nurses, patient and consumer advocacy groups, and so many others, were able to come together with members of both political parties, in both chambers of Congress, to help craft legislation to create a better physician payment system, one that:

- Creates opportunities for physicians to better serve our patients by providing high value, coordinated, and patient-centered care, through innovative Alternative Payment Models (APMs) like Patient-Centered (sometimes called Primary Care) Medical Homes (PCMHs), supported by a better payment system unique to each APM, or through creating incentives within the existing Medicare fee-for-service (FFS) system aligned with value, called the Merit-Based Incentive Payment System (MIPS)
- Streamlines and harmonizes existing quality reporting programs as they migrate into MIPS, which we hope will reduce the current unnecessary regulatory burdens of complying with 3 different quality reporting programs, each with their own measures, deadlines, rewards and penalties.
- Repealed the flawed SGR formula, ridding physicians and their patients from the constant threat of across-the-board payment cuts unrelated to their quality or value.

We sometimes forget, even though it has only been a year, just how important it was to repeal the SGR and replace it with MACRA.

ACP has been a strong supporter of MACRA and embraces its shift from a volume-based payment and delivery system, as was the case under the preceding fee-for-service system with yearly adjustments based on the SGR formula, to one of value, accountability, and patient-centered care. ACP has been active in providing feedback on our MACRA implementation priorities to the Centers for Medicare and Medicaid Services (CMS) in anticipation of the release of the proposed rule and aggressively involved in

educating and providing support to its members about the reforms to come under MACRA. It is on these two areas that I would like to focus my testimony.

OVERVIEW OF ACP VIEWS ON MACRA

Repeal of the SGR has been a priority of ACP's, and nearly all of medicine, for more than a decade. As outlined above, thanks to the passage of MACRA, physicians and their patients no longer will have to be concerned with impending yearly payment cuts as a result of the flawed SGR formula and no longer will this burden of uncertainty be hanging over physician practices. Equally important, the law provides strong incentives for physicians to engage in activities to improve quality; streamlines existing quality reporting programs; and provides additional support to physicians who participate in PCMHs, and other APMs, shown to improve outcomes and the effectiveness of care provided.

More specifically, MACRA offers physicians and other clinicians the opportunity to essentially set their own conversion factor for the determination of their Medicare Part B payments. These payments are determined by relative value units, multiplied by a dollar conversion factor. Although the conversion factor was supposed to keep pace with inflation, the SGR resulted in every physician's conversion factor being cut by the same schedule amount, no matter how cost-effective they were or the quality they provided to patients. MACRA fundamentally changes this, because the annual adjustment in each physician's conversion factor, starting in 2019, will be based on each physician's contributions to improving quality and providing care more effectively: if physicians are able to contribute to improved quality or lowered costs without reducing quality, they will get a higher annual conversion factor adjustment; if they are unable to contribute to better quality and lower costs, they will have a lower annual conversion factor adjustment. This gives physicians far more control over their annual payments, essentially individualizing the conversion factor adjustments each year, rather than the SGR imposing across-the-board cuts on everyone. Or, alternatively, physicians can participate in an APM aligned with value and quality.

It is also important to consider MACRA in the broader payment and delivery system environment, where there is a recognized need and activity by numerous stakeholders (such as other public and

private payers, employers, and consumers) to move toward payment for value rather than the volume of services. Approximately one year ago, the Department of Health and Human Services (HHS) launched the Learning and Action Network (LAN) to bring together partners in the private, public, and non-profit sectors to transform the nation's health system to emphasize value over volume. This effort has actively involved multiple stakeholders to collaborate and develop innovative ideas, recommendations, and resources to help facilitate system-level transformation, with a mission of helping HHS meet and even exceed the goals the Department has set with regard to linking the payment for more and more clinicians and practices to quality and value.

The significant challenges before all of us now are to provide education and support to physicians as MACRA is rolled out, within this evolving health care delivery-system environment, in order to facilitate their success and to ensure that the law is implemented by CMS in line with Congress' intent to truly improve care for Medicare beneficiaries and move toward a meaningful value-based payment and delivery system. Along these lines, ACP is extremely appreciative of the Subcommittee on Health holding this hearing to discuss our efforts, and those of other physician societies, and we are interested in continuing to work with the Subcommittee to ensure the successful implementation of MACRA.

For years, many looking to improve dysfunctional aspects of our health care system have referred to the laudatory goals of the "Triple Aim:" improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. However, when I would mention this to my colleagues in practice, I frequently received frustrated and glazed looks. I am told those are nice big ideas, but "Are you kidding?" And then I am given a list of real-world concerns, such as: "I am struggling with my electronic health record, I am overwhelmed with these regulations, I am unable to deliver care to my patients efficiently with all the prescription and test prior-authorizations; I am given data on clinical metrics and do not know what to do with it; my patients are unhappy because I am taking visit time away from them to deal with all of these hassles; and finally I have to worry every year that my Medicare fees will be cut up to 20 percent or more because of some crazy formula."

In that environment, can anyone wonder why there is such concern about physician burnout? Yet we must recognize that we cannot achieve the Triple Aim if our physicians and other clinicians are suffering from burnout. Hence the Triple Aim is now becoming the "Quadruple Aim" with a fourth goal of "improving the work life of health care clinicians and their staff."

When I explain to my colleagues that the MACRA law will align and simplify some of the measures and reporting; will truly reward those who have made investments or evolved into advanced practice structures like PCMHs or other alternative delivery models where data and clinical metrics are used to improve population health and health care delivery; and will eliminate the yearly financial anxiety created by the dreaded SGR—then those glazed and frustrated looks change dramatically. With surprise, I am then asked, "You mean this law really does things that will simplify our lives in practice and allow us to focus more on delivering high quality care to our patients with no more yearly panic over across-the-board SGR-mandated fee cut threats?" And I tell them, "Yes."

I truly believe that if MACRA can get rolled out with its best intentions implemented well, it is a remarkable "shot in the arm" Congress can give to physicians and the rest of the clinician community to combat burnout, and thereby enable our system to realistically strive for the Quadruple Aim.

ACP'S IMPLEMENTATION PRIORITIES

At this stage in the process, ACP is encouraged that CMS has been open to hearing from us and other stakeholders on how best to implement MACRA so that it allows our members the flexibility and resources they need to be successful with value-based payments, as Congress intended. However, because most of the rulemaking has not yet been issued, it is impossible to assess with any certainty where precisely the agency is in ensuring that implementation proceeds as needed.

The following priorities are the ones that we believe are most important for CMS to address:

1. **Creating a Learning System**. We believe that CMS must use the opportunity provided through the new MACRA law to build a learning health and healthcare system. It is critically important that the new payment systems that are designed through the implementation of MACRA reflect

the learnings from the current and past programs and also effectively allow for ongoing innovation and learning. The College recognizes that taking an approach such as this will require flexibility in design that will be extremely challenging to implement, particularly for a program that must be guided by federal regulations. In our communications with CMS, the College has noted critical areas that should be built with considerable flexibility and an aim of understanding how to best refine the regulations over time based on the data and evidence that emerge, lessons learned, and best practices.

2. **Ensuring Patient-Centeredness.** ACP recommends that CMS work to ensure that patients, families, and the relationship of patients and families with their physicians are at the forefront of the Agency's thinking in the development of both the MIPS and APM pathways, including the development and implementation of the performance measures to be used within these programs. It is critically important to recognize that the legislative intent of MACRA is to truly improve care for Medicare beneficiaries and thus, the policy that is developed to guide these new value-based payment programs must be thoughtfully considered in that context.
3. **Establishing Better Measures and Less Burdensome Reporting.** The College strongly recommends that CMS actively work to improve the measures to be used in the quality performance category of MIPS, as Congress clearly intended as it harmonized the existing Physician Quality Reporting System (PQRS), Medicare Value-Modifier, and Meaningful Use of Electronic Health Records (EHRs) into the MIPS program, while adding a new category of practice improvement measures and reporting. We have provided CMS with detailed recommendations on quality measurement and reporting to CMS in our comments on its quality measurement plan, and in its request for information. Our recommendations included the following:
    - In the short term, ACP encourages CMS to consider adopting a core set of measures that are methodologically sound and Measure Applications Partnership (MAP)-endorsed for use in the MIPS and APM programs. CMS should consider utilizing the core set of measures identified through the America's Health Insurance Plans (AHIP) coalition pending approval by the organizations involved, which includes both physician and consumer organizations and CMS.

- Over the longer term, it will be critically important for CMS to continue to improve the measures and reporting systems to be used in MIPS to ensure that they measure the right things, move toward clinical outcomes and patient experience, and do not create unintended adverse consequences.
- ACP is strongly supportive of filling the critical gaps in quality measurement; obtaining stakeholder input into the measure development process; and focusing on outcomes-based measures, patient and family experience measures, care coordination measures, and measures of population health and prevention.
- ACP also strongly recommends electronic specification of the measures as one of the top considerations for filling measure gaps.
- It is critically important that the data collection and reporting burden related to the quality category (as with all of the MIPS categories) be minimized.
- ACP recommends that CMS work to ensure that performance measurement and reporting becomes increasingly patient-focused.

4. **Creating Realistic Pathways for Patient-Centered Medical Homes.** The College is very pleased that MACRA supports PCMHs, through both the MIPS program and as an APM. Under MIPS, "certified" PCMHs, including both primary care and specialty PCMHs, qualify for the highest possible score for the clinical practice improvement activities category, which is 15 percent of the total weighted score. MACRA also directs HHS to include PCMHs as an APM, without requiring that they take direct financial risk, as long as they can demonstrate the ability to improve quality without increasing costs, or lower costs without harming quality. The College has urged CMS to create multiple ways for PCMHs to obtain certification. The College also supports the inclusion of Medicaid-recognized medical homes as eligible APM entities based on their comparability to medical homes expanded under the Center for Medicare and Medicaid Innovation (CMMI) authority.

Comprehensive Primary Care Plus Initiative:

CMS's announcement this week of the new *Comprehensive Primary Care Plus* Initiative is particularly important to note, because it potentially will create a pathway for thousands of

more physician practices to incorporate the PCMH model into their practices, which would then make it likely that they would qualify as an APM, or receive higher MIPS scores for practice improvement, as authorized by MACRA. CMS envisions that the program will be available "in up to 20 regions and can accommodate up to 5,000 practices, which would encompass more than 20,000 doctors and clinicians and the 25 million people they serve"—a 10-fold increase in the number of participating practices, and a nearly three-fold increase in the number of regions where the program will be offered.[1]

The *Comprehensive Primary Care Plus*(CPC+) program is modeled on the *Comprehensive Primary Care Initiative (CPCi)*, a 4-year pilot of advanced PCMHs that has been rolled out in 500 practices in 7 regions around the country. CPCi is scheduled to wrap up in October of this year; its participating practices will have an opportunity to transition into the new *Comprehensive Primary Care Plus* program, and many more practices will be invited and eligible to join. The College believes that the *Comprehensive Primary Care Plus* program has the potential of offering greater support for practice transformation as well as greater flexibility.

- **Flexibility**: Physicians and their practices can choose from two different participation tracks, with different care delivery requirements and payment methodologies that reflect how advanced they are in incorporating PCMH principles into their care delivery. Track 1 is for those that are less advanced in fully implementing the attributes of advanced PCMHs; track 2 is for more advanced practices.
- **Support for Practice Transformation**. CPC+ can potentially provide practices with more financial support for practice transformation especially when compared to traditional FFS Medicare, because it gives them more Medicare dollars upfront, which will be *in addition* to the amounts they get reimbursed for individual patient encounter (evaluation and management service) codes.

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-04-11.html

- Track 1 practices will receive an average risk-adjusted payment of $15 per beneficiary per month (PBPM); they can earn another $2.50 PBPM if they do well on metrics of quality and utilization. For track 1 practices, these upfront PBPM payments would be *in addition* to getting 100% of their usual Medicare FFS payments for office visits and procedures billed a la carte.
- Track 2 practices would receive an average risk-adjusted PBPM payment of $28 and up to $100 PBPM for the highest risk patients); they can earn an additional $4 PBPM based on performance. However, CPC+ also adds financial risk to the equation. If track 1 practices do not meet their performance metrics, they will have to repay Medicare for the $2.50 PBPM incentive payment. If track 2 practices don't meet their metrics, they would repay Medicare for the $4.00 PBPM incentive payment. For track 2 practices only, their upfront PBPM payments will be offset by reduced payments for separately-billed office visits and other evaluation and management services. In an editorial published in the Journal of the American Medical Association, CMS officials explain how this will work:

  "Track 2 practices will receive an up-front payment of a portion of their expected evaluation and management claims on a per capita basis, independent of claims. Subsequent claims for evaluation and management services will be paid at a commensurately reduced rate. As the ratio of the hybrid payment is titrated up during the model, the reduced payment for billed evaluation and management services will pay practices for the marginal cost of an office visit, making practices 'incentive neutral' to the mode of care delivery and allowing them the flexibility to deliver care in the manner that best meets patients' needs—without being tethered to the 20-minute office visit. Practices might offer non–face-to-face visits (e.g., electronic or telephone), offer visits in alternate locations, or simply provide longer office visits for patients with complex needs. CMS will monitor practices to ensure delivery of quality health care." Non-evaluation and management services for track 2 practices would continue to be paid 100% of the usual rates.

For physicians and their practices considering track 2, the decision likely will be based on whether the additional upfront risk-adjusted PBPM payments, and the flexibility such advance payment provides them, outweighs the loss of revenue that will result when evaluation and management services billed downstream are paid at a lower rate.

The Comprehensive Primary Care Plus program may also give practice access to extra support and revenue from payers other than Medicare: CMS will be seeking formal commitments from non-Medicare payers to support participating practices, and will only launch the program in localities where there is such a commitment from enough payers.

While the College is strongly supportive of the Comprehensive Primary Care Initiative as a pathway for physicians and their practices to transition to PCMHs as recognized by MACRA under both the MIPS and APM pathways, we believe that its success will ultimately depend on Medicare and other payers providing physicians and their practices with the *sustained* financial support needed for them to meet the goal of providing comprehensive, high value, accessible, and patient-centered care, with *realistic* and *achievable* ways to assess each practices' impact on patient care. The College is committed to working with CMS on the details of implementation to ensure that the program is truly able to meet such requirements of success.

5. **Defining Eligible APM Requirements.** The College recommends that CMS employ a very broad definition of entities that should be considered eligible APM entities as a means to promote innovation and recognize the heterogeneity of services and clinicians covered under Medicare. ACP recommends that selection of quality measures for an APM should be based on the goals and design of the specific APM and harmonized with those measures being used within the MIPS program—as well as across the multiple payers that are anticipated would be involved with APMs. The College strongly recommends that certified EHR technology (CEHRT) requirements for APMs be viewed as separate from requirements included under the Meaningful Use EHR Incentive Program. Additionally, we believe that CMS should expand its

definition of nominal financial risk to include recognition of non-billable costs that are currently overlooked (e.g., start-up and maintenance costs, and lost revenue to a system resulting from efforts to reduce unnecessary utilizations).

6. **Creating Pathways for Other Physician-Focused APMs.** The process for approval of Physician-Focused Payment Models (PFPMs) must be clearly defined and implemented to be consistent with the Congressional intent that this approach be a pathway to encourage the development and approval of multiple valued-based payment models. There needs to be a clear understanding that models that are judged by the Physician-focused Payment Model Technical Advisory Committee (PTAC) to meet the established criteria will be tested on a fast-track basis through CMMI and, if determined to be successful, expanded and implemented as part of the APM track in line with the Agency's authority. The College supports the concept of CMS using the PFPM pathway primarily (but not exclusively) to qualify payment models for physician and other healthcare professional specialties who are not eligible to broadly participate in current APMs or models already under review or testing through CMMI. CMS should work collaboratively with medical societies and other organizations developing proposals to provide feedback on drafts and provide data up-front to help in modeling impacts. Furthermore, ACP encourages CMS to assist stakeholders through these processes in developing proposals that would qualify for the APM "bonus" payment contained in the statute. The College is particularly interested in the priority testing of the PCMH specialty practice model.
7. **Providing Technical Assistance to Small Practices and Practices in Health Professional Shortage Areas.** ACP recommends that CMS give consideration to the complexity of transforming to a value-based payment model and provide technical assistance to address identified needs specific to the practice setting. The College strongly recommends that CMS collaborate with the many specialty organizations—at the national, regional, and local levels–to use their established communication channels to provide a consistent message to their membership. MACRA specifically includes $20 million annually for five years for technical assistance to small and rural practices to help them develop the capabilities they will need to successfully participate in the new payment systems established under the law—and CMS has

recently posted a solicitation to begin funding this technical assistance. The College plans to engage with CMS and others to ensure that the most appropriate entities receive this funding.

ACP EDUCATIONAL AND SUPPORT EFFORTS FOR MACRA

Educational and Support Goals

Recognizing the pressing need to make ACP members, as well as other physicians and clinicians, aware of and ready for the Medicare Part B payment changes that they will be facing as MACRA is rolled out, the College initially identified a set of goals around which to focus our efforts and to measure success over time. These goals include the need to help physicians:

- Understand the significant and complex changes in approach to Medicare Part B payments coming their way, the rapid timing of those changes, and why this is an improvement over the previously uncertain payment updates and disparate quality reporting programs.
- Realize the importance of these changes not only to them and their practices, but also to their patients, and the health care system overall—so it is important to get engaged now in order to ensure a successful implementation of MACRA.
- Identify what they and their staff can do now and over the longer term to understand MACRA, make informed decisions, and be successful—including consideration of the PCMH and PCMH Specialty Practice principles.
- Learn—and engage in improving—what ACP has to offer and is developing to help them be successful in the new Medicare Part B payment systems and beyond.

Educational Approaches

As is discussed earlier, MACRA is a critically important law intended to improve the Medicare Part B payment environment for physicians; however, the complex and extensive changes that this law requires will be challenging for physicians to understand and make the needed adjustments for, particularly since physicians also must continue to address their patients' and patient families' daily needs, as well as ensure that their practice business needs and obligations are met. Therefore, the

College has identified physician education on MACRA as a top priority—first outlining the goals listed above, and now putting them into action in a variety of ways.

One of the most direct approaches to education for our members is through in-person meetings. ACP's Internal Medicine Meeting 2016 is taking place here in Washington, D.C. on May 5th to 7th. This meeting, which is held annually, brings together over 6000 internal medicine physicians from across the country to attend more than 200 scientific sessions. During the 2016 meeting, the College will be providing MACRA education through several formal lectures and courses, informal briefings in our exhibit hall, press events, and multimedia displays shown throughout the entire conference. Following this meeting, we expect to be able to provide recorded versions of many of these sessions to our members via our website. Other ACP in-person meetings are held by our chapters. The College has chapters in all 50 states, as well as in the District of Columbia and Puerto Rico, all of which hold meetings each year, generally starting in the Fall. MACRA-focused education and outreach will take place at all of those meetings this year in a variety of forms, including lectures, courses, and multi-media displays.

ACP also provides and supports several publications for our members and beyond. The *Annals of Internal Medicine* is our flagship scientific publication and forms one of the most widely cited peer-reviewed medical journals in the world. The journal has been published for 80 years and accepts only 7 percent of the original research studies submitted for publication. ACP members and staff have been given the opportunity to publish a series of articles over the past several years to address "health policy basics" on a number of current payment and delivery system issues, including PQRS, the CMS Open Payments Program, Medicaid expansion, insurance marketplaces, and ICD-10.[2] This series is expected to continue and will now focus largely on MACRA implementation issues. Additionally, the College is planning to include advertisements in *Annals*, both print and online, to inform readers about our educational and practice support resources.

[2] http://annals.org/solr/searchresults.aspx?q=health%20policy%20basics&fd_JournalID=90&SearchSourceType=3

The College also offers our members the *ACP Internist*[3], a monthly print and online publication that provides news and information for internists about the practice of medicine and reports on the policies, products, and activities of ACP, as well as *ACP Internist Weekly*[4], which provides updates every Tuesday to our members on critical topics. ACP has been actively outreaching to our members via the *Internist* through a series of articles focused on MACRA and its components of MIPS and APMs.[5] Additionally, the College provides our members with the *ACP Advocate*[6], a bi-weekly, e-newsletter created to provide ACP members with news about public policy issues affecting internal medicine and patient care. This publication has also included a series of educational articles on MACRA.[7] Related to the *ACP Advocate* newsletter is a regularly published ACP Advocacy blog by Bob Doherty, ACP's Senior Vice President for Governmental Affairs and Public Policy.[8] This blog has and will continue to include a number of posts focused on helping our members better understand MACRA, how it will impact them, and actions that they should take to prepare and succeed. Finally, another publication that reaches our national membership audience is the *Annual Report from the Executive Vice President* (EVP), where the College's EVP provides a review of the past year's accomplishments, programs, initiatives and collaborations. This report, typically released in July of each year, will also include educational content related to MACRA. At a more regional and local level, ACP's chapters also produce newsletter publications for their members on a regular basis. These newsletters are another way that education and information on practice support resources will be provided.

Beyond in-person meetings and publications, a critical touchpoint for our membership and beyond is via our website, where we have created a section entirely dedicated to MACRA education.[9] This website includes links to all of the educational resources discussed above, as well as practice support resources, and will continue to grow as the MACRA rulemaking gets underway. The website also

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[3] http://www.acpinternist.org/
[4] http://www.acpinternist.org/weekly/
[5] Positioning Your Practice for Alternative Payment Models (ACP Internist, Feb. 2016); Positioning Your Practice for a New Payment System (ACP Internist, Jan. 2016).
[6] https://www.acponline.org/advocacy/acp-advocate
[7] ACP's Recommendations to Congress about Implementing the New Payment System (The ACP Advocate, Dec. 4, 2015); What You Should Know About Alternative Payment Models (ACP Advocate, June 12, 2015); What to Expect in the Post-SGR Era (ACP Advocate, May 8, 2015).
[8] http://advocacyblog.acponline.org/
[9] https://www.acponline.org/macra

allows the College the opportunity to implement a number of innovative multi-media and interactive approaches to education in order to better meet the needs, learning styles, and availability of our members. These approaches either currently or are expected to include frequently asked questions, formal recorded briefings of varying lengths, voice-over PowerPoint presentations, slides with descriptive notes, short videos and audio recordings focused on specific components of the law (and the forthcoming regulations), animated and interactive brochure(s) to help explain implementation details and provide concrete advice, and more. Additionally, the College is developing a new section of the website focused more broadly on practice transformation to ready physician practices for success within MACRA and beyond, given that the health care environment as a whole is moving toward value-based payment- and delivery-system approaches. Both the MACRA and Practice Transformation sections of our website also will allow us to regularly collect and share stories, best practices, and advice from physicians currently engaged in these efforts with their colleagues—as physician-to-physician information is known to be an effective driver of learning and change. Finally, for those that are seeking even further information and advice, the College will be providing a helpline email address so that our members can contact us as needed.

Support Approaches

Taking the education described above to the next level—and provide physicians with practical advice, tools, and resources—is critical to the successful implementation of the law and to ensuring that physicians are able to thrive as it is rolled out. Therefore, the College is actively working to implement short, medium, and longer term assistance opportunities for our members.

MACRA Top Ten Actions for Today:

In the most immediate term, as physicians are learning about the law and as all stakeholders are awaiting the initial rulemaking, many doctors and their staff are wondering what they can and should do now to help ensure success. Given the significant number of unknowns regarding MACRA implementation, this can be a difficult question to answer; however, when one considers the overall intent of the law to improve care and move toward true value-based payment, it becomes more clear that physicians and practices should make every effort to move toward engaging in quality

improvement and practice transformation efforts—as that will be a huge benefit to them no matter how the MACRA rules are ultimately constructed. Along these lines, the College has identified a top 10 list of actions that physician and their staff can do now to prepare. These include:

1. **Understand MACRA** – via any and all of the educational approaches described earlier.
2. **Meet CMS objectives for Meaningful Use (MU) of your EHR to qualify for the EHR Incentive Program for 2016**. This is critically important even now as MU will be rolled into the new MIPS program, with reporting for MIPS beginning as early as 2017 and having a certified EHR also will be a requirement for participation in an APM. While CMS has indicated some significant changes to MU are expected,[10] effective use of an EHR is still a strong and necessary expectation for all practices.
3. **Understand and participate in the Physician Quality Reporting System (PQRS) program for 2016.** As with MU, PQRS will be rolled into the new MIPS program—and while it may undergo changes, ideally with some significant improvements related to the measures used and the administrative burden it requires, reporting and performing well on quality measures is fully expected within both the MIPS and APM pathways. Overall participation in PQRS is still just over 50 percent among clinicians[11]—so it is critically important for more physicians to participate to ensure success.
4. **Implement a formal quality improvement process to improve your reported PQRS and MU quality measures. Ensure that your care adheres to accepted clinical guidelines.** Engaging in quality improvement and focusing on adherence to clinical guidelines will not only positively effect a physician's quality score within MIPS, it is also expected to count toward the Clinical Quality Improvement Activities (CPIA) component of MIPS. Additionally, most current APMs in the marketplace, such as PCMHs and ACOs, call on physicians to actively engage in these efforts.

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[10] https://blog.cms.gov/2016/01/12/comments-of-cms-acting-administrator-andy-slavitt-at-the-j-p-morgan-annual-health-care-conference-jan-11-2016/

[11] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_eRx_Experience_Report_zip.zip

5. **Review your Quality Resource Use Report (QRUR) for accuracy. Contact CMS if there are problems.** QRURs are reports supplied to physicians as part of the Value-Based Payment (VBP) Modifier program. This program is intended to provide comparative performance information to physicians as part of Medicare's efforts to improve the quality and efficiency of clinical care, and is also being rolled into the new MIPS program via the resource use component. QRURs, also known as Physician Feedback Reports, provide information to physicians and medical practice groups about their resource use and quality of care provided to their Medicare patients, including quantification and comparisons of patterns of resource use/cost among physicians and medical practice groups. These reports continue to be critical moving forward as MACRA requires CMS to provide feedback reports to physicians as part of MIPS, in order to facilitate physician awareness of their performance and ideally assist with identifying areas for improvement. By reviewing their QRURs now, physicians can be better informed of how their performance scores are currently calculated and how CMS is viewing their performance to date.
6. **Use a CMS certified vendor for collection of Consumer Assessment of Healthcare Providers and Systems (CAHPS) data. This is required for practices with >100 clinicians, and optional for practices with 2-99 clinicians for 2016 reporting.** Along the lines of the actions already outlined above, improving and measuring patient experience will be an integral component of participation within both the MIPS and APM pathways of MACRA. Therefore, it is critical that practices begin now to gain experience in conducting patient experience surveys—this will not only serve to improve their scores in the new system, but can also facilitate greater engagement of patients and their families in quality improvement efforts by the practice.
7. **Understand the principles of the PCMH and begin implementing in your practice.** The PCMH model of care is strongly incentivized within both pathways of MACRA. In the MIPS program, physicians in practices that are determined to be a "certified" medical home will receive full credit within the CPIA component of their MIPS composite score and are also likely to score well on all of the other components—quality, resource use, and meaningful use of EHRs—given that they are already engaging in collecting, reporting on, and responding to these data. Likewise, within the APM pathway, physicians in PCMHs that are determined to be eligible APMs, will not be required to take on financial risk. This is a critical element of the law, as it

offers the opportunity for smaller and independent practices, who simply cannot bear financial risk beyond the still significant practice transformation costs, to become eligible APMs as PCMHs and reap the appropriate rewards for their efforts. A challenge that primary care practices face in the short term is that CMS has not yet defined how they will define "certified" for MIPS and APMs; however, there are overarching consistent principles across all of the available certification, recognition, and accreditation programs for PCMH that physicians and their care teams can begin implementing now. These principles include adopting new approaches to providing patient access, implementing team-based care approaches (e.g., team huddles), adopting and using innovative approaches to health information technology, and engaging in population management, among others.

8. **Participate in a "medical neighborhood" and provide care coordination to reduce unnecessary visits and testing.** The PCMH model is critically important on its own; however, to further improve care and have a greater impact on longitudinal patient outcomes and experience, specialty practices should begin now to engage with their colleagues as part of a patient-centered medical neighborhood. Within MACRA, physician participation in PCMH specialty practices is also strongly incentivized as part of MIPS. Like their PCMH counterparts, clinicians identified to be part of a "certified" PCMH specialty practice will receive full credit for the CPIA component. It is also anticipated that over time, physicians engaging in this model will be better positioned to participate in an eligible APM.
9. **Empanel and risk stratify your patient population, and implement care management for those at high risk for hospitalization or ER visits.** Empanelment is when a practice takes on assigning individual patients to individual primary care clinicians and care teams with sensitivity to patient and family preference—and is the basis for taking on meaningful population management.[12] Empanelment, along with implementing care management approaches, are practical steps that all practices can take to proactively contact, educate, and track patients by disease status, risk status, self-management status, community and family need. It will ready clinicians and their teams to be successful across all components of MIPS and within APMs no matter how the regulations are constructed.

[12] http://www.safetynetmedicalhome.org/change-concepts/empanelment

10. **Become educated on ACP's High Value Care recommendations and implement them in your practice to prevent unnecessary testing and procedures.** Taking the concepts of empanelment and care management one step further, the College recommends that all clinicians proactively understand what it means to provide high-value care and how they can implement those concepts within their practices. Again, this is something that can begin now and will be beneficial to physicians and their practices, but more importantly, to patients and their families.

To assist practices in taking their MACRA education to the next level and be able to achieve short term success on the top ten items listed above, as well as to thrive in the longer term as MACRA is implemented, the College offers a number of tools and services. These are outlined in greater detail below.

ACP Practice Advisor ®

The ACP Practice Advisor[13] is a premier online interactive tool that offers practices the ability to conduct significant, evidence-based quality improvement based on the most up-to-date clinical guidelines; improve performance on clinical quality measures; implement the principles of the PCMH and PCMH specialty practice models; and improve the overall management of their practice. The Practice Advisor currently contains 45 modules in the following categories:

1. **Building the Foundation**
   These modules address the key attributes and expectations of PCMHs according to the major national recognition and accreditation entities. This guidance is also applicable to all practices and specialties interested in providing patient-centered care, even if not seeking qualification as a PCMH.
2. **Improving Clinical Care**
   These modules help practices apply the attributes of patient-centered care to improve the health of people and populations with specific conditions or clinical concerns.
3. **Managing Your Practice**

[13] https://www.practiceadvisor.org/

These modules help practices deliver efficient and effective care by providing tools and resources that support the day-to-day operations of a well-functioning practice.

4. **Maintenance of Certification**
   Each of these modules qualifies for 20 American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) Self-Evaluation of Practice Performance points.
5. **Specialty Practice Recognition**
   These modules address the key attributes and expectations of specialty and sub-specialty PCMHs according to the National Committee on Quality Assurance (NCQA). This guidance is also applicable to all specialty and sub-specialty practices and specialties interested in providing patient-centered care, even if not seeking qualification as a PCMH.

These modules serve to educate and guide physicians and their care teams as they work to transform their practices in order to improve their ability to provide high quality, safe, efficient, effective, and timely patient centered care. The components of the modules consist of 1) evidence-based background information, 2) case studies that provide examples of how to implement these approaches in the practice setting, 3) ACP Practice Biopsy, an assessment of how the practice is doing, and 4) resources and tools to support implementation. The Case Study and Practice Biopsy focus on the processes that need to be implemented or enhanced to accomplish the transformation from volume based to value driven healthcare. Additionally, as noted above, selected Practice Advisor Modules have been developed to provide MOC credit to physicians for assessing how well a practice is performing with regard to specific clinical quality measures.

The Practice Advisor modules serve to facilitate practice transformation independent of any given payment model, but are clearly approaches that will ensure success within MACRA and beyond.

ACP High Value Care Initiative

ACP's High Value Care (HVC) initiative[14] offers learning resources for clinicians and medical educators, including clinical guidelines, best practice advice, performance measurement, case studies and patient

[14] https://www.acponline.org/clinical-information/high-value-care

resources on a wide variety of related topics. For clinicians, HVC offers resources to help implement HVC principles into practice and focus on optimal diagnostic and treatment strategies, based upon considerations of value, effectiveness, and avoidance of overuse and misuse. These resources include clinical practice guidelines, clinical guidance statements, and best practice advice, along with case studies and learning modules. For educators, the College provides a curriculum for educators, students and Subspecialty Fellows; courses for faculty; as well as a video to help teach faculty how to implement the High Value Care Curriculum. Finally, for patients ACP offers specific advice related to adult vaccines, lower back pain, diabetes and many other areas.

CMS' Transforming Clinical Practice Initiative – ACP's Support and Alignment Network Grant

The College is one of ten Support and Alignment Network (SAN) grants awarded by CMS to provide a system for workforce development, utilizing national and regional professional associations and public-private partnerships that are currently working in practice transformation efforts.[15] SAN grants are part of the overarching CMS Transforming Clinical Practice Initiative (TCPI) effort, with the goal of supporting clinician practices through nationwide, collaborative, and peer-based learning networks that facilitate large-scale practice transformation. The College's work in this area will be focused on providing an array of tools and resources to support clinicians and practices as they transform from volume-based to value-based, patient-centered care—these tools include building out new modules within the Practice Advisor, offering High-Value Care case studies, and referring practices to Practice Transformation Networks (PTNs), which are peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation. While this effort is not directly tied to MACRA, this significant investment by ACP and the other SAN and PTN grantees will offer numerous practices across the country the support they need to be successful.

Quality Improvement Activities

ACP's Center for Quality leads a nationwide quality improvement network of ACP chapters, physicians, their health care teams, residency programs, and other health and quality systems. ACP Quality Connect, as it is called, currently focuses on diabetes, adult immunization, and chronic pain

[15] https://www.acponline.org/practice-resources/business-resources/payment/transforming-clinical-practice-initiative

management. The peer network of nearly 2000 physicians and their teams in 19 states are working to improve management of chronic conditions while linking to multiple performance reporting requirements, including professional requirements for certification and payer-linked programs. More specifically, it has helped more than 200 practices submit for PQRS and Bridges to Excellence, plus earn MOC part IV credits. This program is also linked to ACP registries including the Genesis QCDR, described below, and the Diabetes Collaborative Registry.

Quality Reporting Registries: Genesis Registry and PQRS Wizard

The College has partnered with CE City to offer our members the ACP Genesis Registry™,[16] which is a CMS-approved qualified clinical data registry (QCDR) for use with PQRS. As a QCDR, the Genesis Registry can include data from multiple payers, allow for continuous exchange of EHR data and benchmarking, help physicians meet the requirements of Stage 2 MU, and provide meaningful feedback reports to clinicians. This registry currently has more than 30,000 providers using it to attest to MU, and includes all of the 64 eMeasures across all 6 National Quality Strategy (NQS) domains. Calculated measures represent more than 123 million patient records. The Genesis Registry is also linked to ACP's growing area of clinical quality improvement programs, described above.

ACP also offers the PQRS Wizard[17]–a tool that provides a step-by-step approach to help ensure that eligible professionals (EPs) meet all of the data, scoring, and attestation requirements before they submit their PQRS reports to CMS.

Both of these registries are critical to ensuring physician and other clinician success in reporting on quality measures, which will continue to grow in importance as MACRA is implemented.

The Physician & Practice Timeline℠: Professional Requirements and Opportunities

The College has created The Physician and Practice Timeline[18]—an online tool that provides a helpful at-a-glance summary of upcoming important dates related to a variety of regulatory, payment, and

[16] https://www.medconcert.com/content/medconcert/Genesis/
[17] https://acp.pqrswizard.com/default.aspx
[18] https://www.acponline.org/practice-resources/regulatory-resources/physician-practice-timeline

delivery system changes and requirements, including PQRS, the Value-Based Modifier Program, MU, Open Payments Program, transitional care management (TCM) codes, the chronic care management (CCM) code, and the advance care planning codes. The Timeline then links users to practical tools and resources to help them with successful participation—and users can choose to opt into a text alert system that will actively inform them of significant regulatory changes, new resources, and upcoming deadlines. This service will be evolving as MACRA is implemented to continue to provide practical updates and support for physicians and their care teams related to MIPS and APMs.

AmericanEHR Partners™

AmericanEHR Partners[19] provides physicians, state and federal agencies, vendors, and funding organizations across the United States with the necessary tools to identify, implement, and effectively use EHRs and other healthcare technologies. This tool was developed by Cientis Technologies and the American College of Physicians and is dedicated to the creation of an online community of clinicians who use information technology to deliver care to Americans. Through education, social media, and the collection of peer contributed data this service organizes information to facilitate optimal decision making. AmericanEHR Partners also includes critically important MU attestation data in an easy-to-read format. Given that MU, and effective use of health information technology, is an ongoing component of both MIPS and APMs, this tool provides an invaluable service to physicians, their care teams, and other stakeholders.

Patient-Care Resources

In addition to resources aimed at helping clinicians and their practices, the College has also developed information to help patients and their families understand health conditions and facilitate communication between patients and their healthcare team.[20] These resources are organized by condition, including allergies and asthma, diabetes, heart health and many others, and are available in a variety of formats including self-management guides, videos, and one- and two-page topic summaries.

[19] http://www.americanehr.com/
[20] https://www.acponline.org/practice-resources/patient-care-resources-and-tools

ACP also offers patient care tools to assist doctors in effectively maintaining and enhancing the doctor-patient relationship and has partnered with The Wellness Network are partnering to deliver new patient education programming that will be available via The Wellness Network's Patient Channel, an in-hospital TV network and online portal.

Under Development – MACRA Guidance Tool

The College is in the process of developing an online tool to assess a clinician's practice, help them decide whether MIPS or APM payment track is the best choice for their practice, and point them to customized resources to facilitate implementation of changes to comply with MIPS or APM. The tool will gather the following information from the practice:

- practice description: type, size, structure, geography, patient demographics;
- current quality improvement, health information technology, resource use, and quality measurement activities; and
- readiness to take on new practice activities.

It will then direct them to targeted educational information and resources to facilitate success, including many of the tools and services outlined above. It is expected that this new tool will be online and available to ACP members by the end of 2016.

CONCLUSION

The College would again like to sincerely thank Chairman Pitts and Ranking Member Green for convening this hearing and for your shared commitment to ensure that the payment and delivery system reforms created under MACRA are implemented successfully and as intended by Congress. We appreciate the Committee inviting input from the physician community during the implementation process—and are extremely interested in continuing to work with Congress and with CMS to ensure that MACRA is a success. Our hope is that the information outlined today will provide the Committee with assurance that the College is committed to our support for MACRA, to providing constructive feedback to CMS and to educating and supporting physicians and other clinicians in their transition to value-based payment within Medicare FFS and beyond.

Mr. PITTS. The Chair thanks the gentleman. Thank you for your testimony.

We're still having trouble with the mics. So Dr. Wergin, make sure you pull that close to you and make sure the mic is on.

The Chair now recognizes Dr. Wergin, 5 minutes for an opening statement.

STATEMENT OF ROBERT WERGIN

Dr. WERGIN. Chairman Pitts, Ranking Member Green and members of the subcommittee, thank you for this opportunity to address you this morning.

My name is Dr. Robert Wergin. I chair the American Academy of Family Physicians board of directors. The AAFP is an organization of 120,000 members. I am pleased to be asked to speak about Medicare Access and CHIP Reauthorization Act implementation.

First of all, I want to thank all of you for your effective bipartisan leadership in repealing the much-despised Medicare SGR and putting into place payment reforms that clearly emphasize value-based health care.

More importantly, thank you for putting together legislation that will make a real and positive different in the lives of your constituents.

MACRA implementation will be a major shift in Medicare in a very short period of time. These changes, as dramatic as they may be in the coming years, are consistent with the key principles of practice transformation that the AAFP has supported for over a decade.

For example, almost 10 years ago the AAFP, along with four major primary care organizations developed the joint principles for the patients that are in a medical home that promotes coordinated care, quality and safety and patient access.

Consistent with those principle we believe that the practice transformation necessary to make MACRA successful will mean better care for patients, better professional experiences for our physicians and better control of healthcare costs.

We hope it will also bring back the joy of the practice of medicine to our members. As I travel from State to State meeting with AAFP chapters I hear a lot of anxiety related to MACRA, particularly for my colleagues in rural and underserved areas.

I challenge my colleagues to be optimistic. MACRA reform will not be easy but it's much better than what physicians faced before the law was enacted. Instead, I urge them to take advantage of the AAFP resources they can utilize to begin transforming their practices now.

The AAFP believes MACRA is by intent and design a law aimed at transforming our healthcare delivery system into one that is based on a strong foundation of primary care.

As I fully explained in my written testimony, the whole person and complex care that primary care physicians provide helps improve patients' outcomes and constrain overall healthcare costs, which are also consistent with the law's intention.

Also, the alternative payment models will improve how healthcare systems value primary care and the services that are fundamental to disease prevention, chronic care management and

population health—all areas of health care that a fee for service system cannot adequately address.

Although MACRA is among the most significant reforms to occur in decades, many of our members may not be aware of the upcoming changes or do not know their level of readiness for MACRA implementation.

As a result of that, the AAFP has launched a comprehensive multiyear member education and communications effort designed to simplify this transition.

Called MACRA Ready, the effort will include a variety of tactics designed to get the word out to our members starting with a dedicated content page on afp.org.

One of the best primers is an article in the April/March issue of Family Practice Management. Other MACRA content already available to AAFP members are MACRA 101, frequently asked questions, MACRA time line, AAFP news articles, MACRA readiness assessment tool and a MIPS APM calculator and decision tree tool as well.

The AAFP is dedicating considerable time and thought into preparing our members for MACRA and that is reflected in our wealth of available resources. The AAFP is also supporting MACRA implementation by advising CMS about the agency, how the agency might handle many features of the new law which are fully outlined in my written statement. They include but are not limited to the critical importance of an interoperable electronic health record. The AAFP has also shared recommendations regarding the importance of issuing regulations that are less cumbersome and more user friendly for physicians.

Ultimately, we believe these concerns could be address as the process moves forward and we truly believe that the vision for practice transformation, better patient care, lowering costs and return to the love of the practice of medicine is achievable.

Once again, I want to thank you for your kind invitation to speak about MACRA and its implementation. I look forward to answering your questions.

[The prepared statement of Dr. Wergin follows:]

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

By

Robert Wergin, MD, FAAFP
Board Chair
American Academy of Family Physicians

To

Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

April 19, 2016

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Chairman Pitts, Ranking Member Green, and members of the Subcommittee:

Thank you for the opportunity to address you this morning. I am Dr. Robert Wergin, and I chair the AAFP Board of Directors. I am pleased and honored to accept your invitation to speak with you about the *Medicare Access and CHIP Reauthorization Act* (MACRA) that repealed the much-despised Medicare Sustainable Growth Rate (SGR) payment formula and instituted a path to payment reforms that clearly emphasizes value-based systems. But before I get to that, I would like to take the opportunity to thank you once again for your effective, bipartisan leadership in putting together such significant legislation that will make a real, positive difference in the lives of your constituents.

As you requested, I am prepared to review with you how the American Academy of Family Physicians is assisting our 120,900 members nationwide to get ready for MACRA. This, of course, is no small task. MACRA is a major shift in how Medicare pays for health care and the time allotted for that shift to take place is relatively short. However, Congress passed MACRA to move us away from a system that rewarded volume and toward one that would support value. We are especially encouraged that, as part of this transition to value-based payments, the law promotes and establishes primary care as foundational to our health care system. These changes, as dramatic as they may be in the coming years, are consistent with the key principles of practice transformation that the AAFP has supported for over a decade.

For example, the AAFP, along with the other major primary care organizations developed the joint principles for the patient-centered medical home that promotes coordinated care, quality and safety, and patient access. That vision is consistent with how we hope MACRA will allow physicians, like me, to provide the best patient care possible.

We believe that the work needed to bring about the change in how physicians provide medical care that will make MACRA successful will mean better care for patients, better professional experience for physicians and their medical teams, and better control of health care costs. We think it may even bring back the joy of medical practice for family physicians.

The Role of Primary Care

First of all, let us be clear about what family physicians do. All of our physician members in practice provide primary care, which is defined variously in different contexts. But no matter the context, primary care always includes first contact of care, continuity of care,

comprehensiveness, connectedness and coordination of care. Family physicians are not limited in offering primary care – they are trained to treat women and men, children and adults, young and old; indeed, everyone in their community. They care for patients from birth to death. As primary care physicians, they are not limited by organ system, disease condition or injury. Also in their role as primary care physicians, they are key to preventive health and to the management of chronic conditions and to the health of the communities of which they are a part.

Most of our physician members in private practice have contractual relationships with 7 or more health insurance plans, including Medicare and Medicaid. They are located in frontier, rural, suburban and urban areas. They practice in a variety of professional arrangements, including privately owned solo practices as well as large multi-specialty integrated systems and also public health agencies like the Indian Health Service and the Veterans Health Administration system.

Our work involves a great deal of complexity. We treat patients from all walks of life and whose medical conditions, whether they may involve obesity, asthma or diabetes management, are influenced by their community, socio-economics, and their well-being. The complexity increases as the proportion of people with multiple chronic conditions grows. This is especially true for patients who live in rural and underserved communities, like mine, where the primary source of health care is the family physician. For example, a recent report in the journal *Primary Care Diabetes* concluded: "Office-based visits to primary care physicians are made increasingly complex by growing population morbidity. Adults with diabetes report more conditions being cared for per visit with primary care physicians than with subspecialty physicians." Since relatively few people experience only a single chronic condition, the role of the primary care physician is to help the patient respond to several treatments provided in different settings and by other medical specialists.

We know patients who have access to a consistent source of primary care live longer, enjoy better quality of lives, and have lower overall health costs on a per-capita basis. The "whole person" care that primary care physicians provide also helps control overall health care costs. However, the reality is that this primary care is terribly undervalued and system fragmentation contributes to suboptimal outcomes. This is why family physicians were pioneers in system delivery reform and why family physicians are looking to MACRA to signal an improvement in

how care is delivered and paid for. The AAFP believes that MACRA is, by intent and design, a law aimed at transforming our health care delivery system into one that is based on a strong foundation of primary care.

The Alternative Payment Models that are part of the new system of payment offer the promise of changing how the health care system values primary care and the services that are fundamental to disease prevention, chronic care management and population health – all areas of health care that a fee-for-service system cannot adequately address.

The AAFP's Preparation for MACRA

Passage of MACRA is among the most significant changes to occur in medicine in decades—a positive result of family medicine's demands for delivery system and payment reforms, and an opportunity to improve the quality of care delivered. That said, we also understand that many of our members may not be aware of or paying attention to upcoming changes to Medicare payment, or do not know their level of readiness for MACRA implementation. As a result, the AAFP has launched a comprehensive, multi-year, member education and communications effort designed to simplify the transition and provide the guidance members need to realize the benefits of MACRA and value-based payment, both for their patients and their practices.

Called "MACRA Ready," the effort will include a variety of different tactics designed to get the word out to our members, starting with a dedicated content page on aafp.org (www.aafp.org/macraready). Updated educational resources will be posted to this site on a regular basis. One of the best primers on MACRA to date is an article we recently published in the March/April issue of *Family Practice Management* (http://www.aafp.org/fpm/2016/0300/p12.html). Other MACRA Ready content already available to AAFP members and the public includes:

- MACRA 101 FAQ (http://www.aafp.org/practice-management/payment/medicare-payment/faq.html)
- MACRA Timeline (http://www.aafp.org/dam/AAFP/documents/practice_management/payment/MACRATimeline.pdf)
- *AAFP News* articles (example: http://www.aafp.org/news/practice-professional-issues/20160405macraeffort.html)

Future MACRA Ready information will be divided between basic information, tools and resources, and detailed practice transformation resources. We are attempting to strike a balance between basic/general information that can be public-facing while we offer member value in the form of tools/resources that are restricted to members only. Below are examples of the products and services that will be available for our members:

- MACRA Ready explainer video
- MACRA Ready launch remarks (video) by AAFP President Dr. Wanda Filer
- Executive Summary of research illustrating the value of family medicine
- Additional *AAFP News* articles
- MACRA readiness assessment
- Web-enabled mobile MIPS/APM calculator and decision tree
- Enduring presentations, including recorded webinars, CME Bulletins
- Educational inserts that are distributed with *Family Practice Management*
- Implementation toolkits
- Video vignettes of the MACRA PPT presentation by Dr. Mullins

The AAFP's Concerns with MACRA Implementation

At this time, of course, we do not know many of the details of how MACRA will be implemented as we await the proposed rule to be issued by CMS. Last week, we advised CMS of our concerns with how the agency might handle many features of the new law. Specifically, we recommended that CMS:

- Address the flaws in the existing fee-for-service payment system that undervalue primary care, since the fee-for-service payment will remain part of most new payment models, including the Merit-Based Incentive Payment System (MIPS)
- Ensure the existence of an APM for primary care physicians
- Use the Core Measure set developed by the Core Quality Measures Collaborative
- Reexamine the structure and documentation guidelines required for evaluation and management services
- Avoid the real potential for overly complex regulatory implementation, especially because it is essential to keep the new systems as simple as possible to encourage participation
- Define the Patient Centered Medical Home without requiring third-party recognition

- Grant greater flexibility in the initial MACRA performance year, because it is unrealistic to begin measuring performance on January 1, 2017, since regulations will not be finalized until late this year
- Adopt a 90-day reporting period for meaningful use in 2016
- Attribute patients prospectively to the physician practice, so patients can engage with the medical team and physicians will know for whom they are responsible for quality reporting

CMS's Comprehensive Primary Care Plus Initiative

Last week, the Center for Medicare and Medicaid Innovation (CMMI) within the Centers for Medicare and Medicaid Services (CMS) announced the Comprehensive Primary Care Plus (CPC+) Initiative, which is a bold and positive attempt to address the undervaluing of primary care. According to the CMS announcement, the CPC+ is a five-year, regionally based, multi-payer advanced primary care medical home model. It will pay participating practices a prospective per-beneficiary per-month care management fee that is based on beneficiary risk. In addition, CPC+ practices in Track 2 will receive a modified fee-for-service payment for the specific services offered in the office visit, and all CPC+ practices are eligible for a performance-based incentive payment, pre-paid at the beginning of the year. While there are details to work out, CMS is moving very aggressively to begin accepting applications from as many as 20,000 physicians in as many as 5,000 practices who are caring for up to 3.5 million Medicare fee-for-service beneficiaries, and millions of other Medicare Advantage, Medicaid, and commercial patients.

The AAFP hopes that the practices that accept the challenge to be part of the CPC+ initiative will be eligible for designation as an Alternative Payment Model and serve as templates for other primary care practices.

Conclusion

Once again, thank you for the invitation to discuss with this committee the importance of MACRA to family physicians and its potential to build a health care delivery system upon the foundation of primary care. And thank you as well for your leadership in replacing the SGR with MACRA and helping physicians forge ahead toward a value-based health care system. The implementation process will not be easy but we anticipate that the new world under MACRA will be a vast improvement over the one we had with the SGR.

Mr. PITTS. The Chair thanks the gentleman.

Now recognizes Dr. McAneny, 5 minutes for her opening statement.

STATEMENT OF BARBARA L. MCANENY

Dr. MCANENY. Good morning. I'm Dr. Barbara McAneny, a hematologist oncologist from New Mexico and immediate past chair of the American Medical Association board of trustees.

Thank you for inviting us to this hearing on MACRA focusing on physician efforts to prepare for Medicare payment reform.

As background, my practice is the New Mexico Cancer Center, which provides multidisciplinary outpatient cancer care at multiple sites including under served rural areas.

As a practicing physician, I felt the burden of a broken SGR payment system for many years. With half of my patients covered by Medicare, the threat of significant payment cuts was very real and jeopardized the viability of my practice every year.

How could I justify hiring people to provide patient education and care coordination when I would have to lay them off if Medicare cuts went through?

How could I continue to provide services in our most under served area, my Gallup clinic, if the Medicare cuts meant that I couldn't make payroll?

The passage of MACRA now provides physicians with the opportunity to focus on our patients by creating a single performance reporting program, known as MIPS. The law gives us the opportunity to streamline measures, reduce reporting burden and create flexibility to encourage physicians in every specialty to participate and improve care.

MACRA also promotes innovation by encouraging new alternative payment models. APMs can be tailored to specific patient populations to drive care improvement, leverage technology and promote new treatments.

Importantly, the law acknowledges physician leadership is needed in developing APMs which not only promotes participation but protects patients and can drive down costs.

To ensure physicians can take advantages of these MACRA improvements, the AMA is providing information and resources to physicians. We know that physicians are in many different stages of readiness for MACRA and few have detailed knowledge of the law's requirements.

The AMA is eager to work with CMS so that together we can teach all physicians how to avoid the penalties that could threaten the existence of their practices, especially those working in medically under served areas who lack the resources of larger more affluent areas.

To improve outreach, the AMA has created numerous free online tools and resources to guide physicians. This includes basic information for those with little understanding of MACRA.

The AMA had also created CME training modules that can provide assistance on key issues for MACRAs such as EHR implementation and team-based care.

We are also helping physicians decide what path, either MIPS or APMs, is right for them by creating a payment evaluator tool to as-

sess their practice. For those interested in moving to alternative payment models, the AMA has created this guide on physician-focused APMs.

This tool walks through seven different models describing the components and benefits of each including examples on how the model could be implemented.

My own experience with APMs have shown that when physicians have the opportunity to innovate, these models can be successful.

In 2012, I received a CMMI grant to replicate across the country how my practice was providing cancer patients with better care at a lower cost.

By implementing a medical home model, we were able to cut hospitalizations in half. This is a model for chronic care management.

CMS must now implement MACRA to ensure that the law successfully achieves the goals intended by Congress. Knowing that the devil can be in the details, the AMA has provided CMS with guidance from physicians to inform its proposed rule.

We have convened specialty and State societies to build consensus and have created a MACRA task for as well as two work groups, one on MIPS and another on APMs, to examine specific issues related to our program.

In addition to our comment letters and responses to RFIs we've also held listening sessions for CMS and other stakeholders to inform MACRA implementation.

In conclusion, we are hoping the forthcoming regulations from CMS will promote the smooth and successful implementation of MACRA by consolidating and improving current reporting programs, providing broad opportunities for participation in the APMs, addressing current concerns with methodologies of performance measurement and providing physician practices with CMS data needed to evaluate the models.

MACRA provides the opportunity to help every physician in every practice setting make the changes that provide meaningful improvements in the care they give to the patients they serve.

We thank the subcommittee for your continued efforts on this issue and look forward to working with you to ensure a successful start to MACRA.

[The prepared statement of Dr. McAneny follows:]

TESTIMONY

of the

American Medical Association

before the

U.S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health

Re: Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

Presented by: Barbara L. McAneny, MD

April 19, 2016

TESTIMONY

of the

American Medical Association

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U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health

Re: Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

Presented by: Barbara L. McAneny, MD

April 19, 2016

The American Medical Association (AMA) applauds the Committee on Energy and Commerce Subcommittee on Health (Subcommittee) for its leading role in enacting the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). In passing this law, the Subcommittee and Congress recognized the problems with the broken system of reimbursement patches under the Sustainable Growth Rate (SGR) formula and provided clear direction to improve payment, streamline quality reporting, and promote health care delivery innovation. The AMA strongly supports the Subcommittee's current efforts to ensure the new law is a success for both patients and physicians. Moving forward, we now need to ensure that the forthcoming regulations from the Centers for Medicare & Medicaid Services (CMS) promote the smooth and successful implementation of MACRA in a manner that facilitates a strategic quality framework that supports innovation, improves care delivery for patients, and leads to more sustainable physician practices, as intended under the statute.

To ensure MACRA works for all stakeholders, we wish to highlight the following:

- The AMA believes MACRA provides an opportunity to improve current performance programs and increase the availability of alternative payment models (APMs).
- To assist in moving towards these goals, the AMA is taking an active role by developing practice tools, educating physicians, convening stakeholders, and providing feedback to agency officials.
- Successful implementation of MACRA will require rulemaking that will constructively 1) consolidate performance reporting; 2) broaden participation in APMs; and 3) improve measurement to reflect differences across medical practices.

MACRA Improvements and Opportunities for Innovation

As this Subcommittee well knows, on April 14, 2015, a large bipartisan majority in Congress passed MACRA, enacting significant changes to the Medicare physician payment system. The AMA strongly believes that the law creates improvements over the existing system. First, it permanently repeals the flawed SGR formula that threatened to cut Medicare payments for clinicians' services. This change alone allows more time and resources to be spent focusing on care rather than worrying about how to sustain practices. In its place, the law stabilizes payments for physicians over the next five years by providing annual .5 percent payment increases. It also reduces overall financial penalties physicians faced from the numerous quality reporting programs while providing for bonus incentives—for example, in 2019 physicians could have incurred a total financial penalty of eleven percent; under MACRA, the maximum penalty in 2019 is reduced to four percent.

The law also enacts a new Merit-Based Incentive Payment System (MIPS) that combines the requirements of the Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VBM), and Medicare Meaningful Use (MU) Electronic Health Record (EHR) Incentive Program. By creating a single performance reporting program, the law provides an opportunity to reset and improve quality measurement as well as the other reporting requirements. Specifically, MIPS has the ability to streamline measures, reduce reporting burden, create flexibility to report on clinically relevant measures, encourage participation, and overall improve care.

MACRA not only improves the existing payment structure but also provides incentives to promote further innovation in the health care system. The law allows physicians who participate in qualifying APMs an exemption from the MIPS requirements, permitting them to establish new ways to coordinate care. The law further encourages these innovative approaches by providing financial support for APM participation, equal to five percent of the prior year's aggregate Medicare expenditures, to help manage the investment, risk, and other costs in more advanced models.

MACRA also creates a process to expand the APM options available to physicians. The law encourages new models, especially for specialists, which can be developed directly with practicing physician insight. To achieve broader input, MACRA created the Physician-Focused Payment Model Technical Advisory Committee (PTAC), a new independent advisory committee, which will specifically focus on and assess physician payment models. This provides a valuable opportunity for physicians to develop and submit their own ideas for APMs.

AMA Efforts to Support MACRA Implementation

1. Outreach to Physicians

To ensure physicians understand and can take advantage of the benefits of MACRA, the AMA is actively working to educate physicians and practices about the new law. Our market research with practicing physicians and practice administrators found that many physicians are unaware of the details of MACRA, how it will influence their practice and patients, and deadlines for the new requirements. Moreover, physician knowledge of the new law's

requirements varies, with some practices ready to move to APMs while others are still working to implement the existing quality reporting programs.

To improve outreach, the AMA is allocating significant resources for a comprehensive communication and education campaign and has created multiple resources for physicians to help guide them through the new law. This includes basic information for those with little understanding of the law, including detailed summaries and presentations that break down MACRA into plain language interpretations. The AMA has also created a tool to address state-by-state concerns. Using this information, physicians will be able to view the available delivery and payment models in each state, the funding benefits for the state's Medicare physicians, and the number of beneficiaries in each region that will be impacted by the new law. The AMA also maintains an extensive practice transformation platform, known as Steps Forward, which offers Continuing Medical Education (CME) training modules for physicians and their practice administrators on many issues related to MACRA, including EHR implementation and improving team-based care. At the end of April we will launch a new module on implementing value-based care and we will offer a CME webinar on this module in May. We also are developing a free payment model evaluator for physicians and practice managers to assess practice readiness, and provide implementation resources for MIPS and APMs. All of these resources are or will be available this summer at no cost on our AMA website.

The AMA is also a grantee of the CMS Transforming Clinical Practice Initiative (TCPI). As a Support and Alignment Network (SAN) Awardee, the AMA is promoting the goals of the TCPI to the TCPI network of clinicians through education about MACRA, CME, dissemination of best practices, promotion of clinical data registry use, and provision of tools and resources on APMs.

For more advanced practices, the AMA has developed numerous tools and resources to assist physicians in navigating APMs. Before MACRA was even enacted, the AMA, in June 2011, formed the Innovators Committee, an advisory group of physicians with hands-on experience in the development and management of innovative health care delivery and payment models. The Committee specifically focused on global budget and episode-based payments to help inform physicians of these models and how they can implement them within their practices.

In 2014, the AMA contracted with the RAND Corporation to take the first in-depth look at the impact that commercial APMs have on physician practices, their professional lives, and the delivery of patient care. This study specifically evaluated a broader array of models, including capitation, episode-based and bundled payment, shared savings, pay-for-performance, and retainer-based practices. Key findings from the study were that practice leaders are already changing organizational models in response to new payment models but that many physicians at the front lines need support and guidance to optimize the physician work under APMs. Addressing physician concerns about operational details of APMs could improve their effectiveness. Harmonizing key components of APMs across payers, especially performance measures, would enable physician practices to respond constructively. Physicians will also need enhanced access to data to succeed in alternative models.

Furthermore, the AMA has created a comprehensive guide to physician-focused APMs. This tool outlines the current barriers to adopting new models but seeks to overcome these challenges by highlighting the characteristics of successful APMs. It then walks through seven different models, describing the components and benefits, and listing examples of each

type of APM to outline these options for physicians so that they can evaluate them for their own practices. We believe this tool provides practical guidance and will assist different specialties in assessing models that can work for their patients.

2. Engagement with CMS and Other Stakeholders

The AMA is also working alongside CMS, specialties, states, and other stakeholders to ensure that MACRA is implemented in a manner that follows Congressional intent and supports a more efficient and high quality health care system. Specifically, the AMA has convened a taskforce of physician national medical specialties and state medical societies to build consensus on how best to implement the law's changes. The AMA has also established two technical workgroups, one focusing on MIPS and another on APMs, to examine specific issues related to each program. These workgroups have allowed physician representatives to openly engage in discussions and formulate proposals on how MACRA can and will work to improve care.

The AMA has also provided extensive feedback to CMS through numerous comment letters on specific aspects of MACRA implementation. These comments include how to define eligibility and the low-volume threshold for participation in MIPS, the scope of clinical practice activities, and the reporting mechanisms for each quality performance category, among others. In addition, the AMA has responded to CMS' requests for information that provided advice on the agency's proposal for a quality measure development plan and episode groups.

Furthermore, the AMA has hosted a number of listening sessions with CMS for different specialties and other stakeholders. Topics have addressed how to measure performance, the establishment of different episode groups, and specific concerns related to specialty practices. We plan to host future sessions, including one dedicated to how specialties can develop new APMs and an overview of the proposed rule once it is published.

Overall, the AMA is actively engaged in helping physicians navigate MACRA and is working to assist agency officials as it implements the law. The AMA will continue these efforts and add additional resources as CMS announces proposals related to MACRA and finalizes its regulations.

Necessary Steps to Ensure a Successful Implementation

In MACRA, Congress provided new authority to improve physician quality reporting and expand APMs. We are hopeful that CMS will seize this opportunity to implement these changes to ensure the law achieves its potential. To do so, the AMA has asked CMS to address key operational issues in its proposed rule to provide clarity for physicians and resolve existing barriers that prevent care improvements. The following provides a high-level overview of the issues we believe are necessary for CMS to address in its rulemaking; more detailed AMA guidance can be found in the numerous comment letters we have submitted to the agency.

1. Consolidating Performance Reporting

A key factor in medicine's support for MACRA was the law's promise to create a new MIPS program that, unlike the existing structure, establishes a single, coordinated approach to

performance reporting. Currently, physicians view measurement as burdensome, inaccurate, and often outdated. Reporting requirements are also extremely costly, with estimates finding that practices spend more than 700 hours per physician and more than $15.4 billion dollars to report quality measures.[1] The MU program, in its current form, remains particularly challenging due to technology that fails to perform as promised and measures that are beyond the control of physicians. Given that MU performance constitutes 25 percent of the overall MIPS score, it is vital that this program does not become a barrier to overall success under the new performance program.

The AMA believes MACRA provides CMS with the opportunity to significantly improve quality reporting rather than maintaining current requirements without major modifications. Specific issues we believe CMS should address with respect to MIPS include: moving away from a pass-fail program design to accommodate the needs of different practices, specialties, and patient populations; improving the timing of feedback reports; and minimizing unnecessary data collection and reporting burden. Ultimately, MIPS should streamline the number of reporting requirements while giving physicians reporting options to accommodate differences in specialty, site of service, type of practice, and patient mix. Also, as discussed in more detail later, the tools for measuring performance, particularly in the resource category, need significant improvement.

Already, CMS has been responsive to this concern with respect to the MU program, promising physicians needed changes to it. The agency has openly discussed its intent to make the MU program more flexible by customizing technology to individual practice needs, rewarding providers for outcomes rather than merely data entry, and taking action against data blocking practices.[2] We believe all of these steps must be accomplished to make MU work for physicians and patients. How soon CMS will implement these changes, whether it will significantly alter the other quality programs, and if these modifications avoid additional burdens on practices will further determine if MACRA policies will truly improve quality reporting.

2. Broadening APMs

With respect to APMs, the AMA believes success will depend on whether models are readily available for all practices. Physicians have already made significant progress in adopting and engaging in APMs—in 2011, no Medicare payments were made through APMs; by 2014, approximately 20 percent of payments were made through these arrangements.[3] Yet, these existing models may not provide real opportunities for all specialties and practices. MACRA regulations must provide a clear pathway for physicians to propose new models and ensure physicians in every specialty can participate.

To engage more physicians, we have urged CMS to expand APM options. MACRA regulations must establish a clear pathway for rapid approval and implementation of

[1] Lawrence P. Casalino et al. US Physician Practices Spend More Than $15.4 Billion Annually to Report Quality Measures. Health Affairs. March 2016. Available at http://content.healthaffairs.org/content/35/3/401.abstract

[2] Andy Slavitt and Karen DeSalvo. EHR Incentive Programs: Where We Go Next. January 19, 2016. Available at https://blog.cms.gov/2016/01/19/ehr-incentive-programs-where-we-go-next/

[3] Patrick Conway et al. Health Affairs. MACRA: New Opportunities for Medicare Providers Through Innovative Payment Systems. September 28, 2015. Available at http://healthaffairs.org/blog/2015/09/28/macra-new-opportunities-for-medicare-providers-through-innovative-payment-systems-3/

physician-focused APMs that establish different approaches to delivering patient care. CMS must avoid adding unnecessary and burdensome requirements to APMs that cause resources to be spent on administrative costs rather than helping patients. Physicians also need data and assistance from CMS to identify models that are appropriate and relevant to their practices.

Particularly in the early years of MACRA, we believe the agency should take an expansive definition of financial risk to promote broad physician participation in APMs. If CMS defines financial risk too narrowly, it will only recognize the most advanced practices and risks slowing momentum towards adopting new models. This term should therefore incorporate those physicians who demonstrate movement toward APMs, encouraging interest and better highlighting the benefits of working towards different payment models. In addition, the definition of nominal financial risk should recognize the significant up-front investments and ongoing costs that must be incurred by physicians who develop and implement these new models and not solely focus on shared savings and losses.

3. Improving Measurement

Another factor that must be addressed in the proposed MACRA rule is how to improve methods for measurement, especially attribution and resource use. Currently, PQRS and VBM do not appropriately take into consideration the numerous differences between practices. Often CMS simply uses hospital cost and outcome measures for physicians, ignoring the differences between these providers and the care setting in which they treat patients. We are also hopeful that CMS will develop more sophisticated risk adjustment measures that allow for more granular specialty comparisons, more accurate attribution methods across specialties, and better recognition of additional cost influencing factors, such as site of service. These changes are needed to eliminate flaws that have made practices with high risk patients more susceptible to penalties.

Furthermore, physicians need more timely feedback and data on their practices to successfully participate in both MIPS and APMs. Current reports often lag by more than two years, making this data unusable or irrelevant. Congress attempted to address this problem in MACRA by adding language that the performance period be "as close as possible" to the time payment adjustments are made. We have therefore urged CMS to make every effort to reduce the gap between the performance period and the payment year in order to provide more actionable and relevant data. We believe MIPS feedback reports must be readily accessible, correct, and actionable.

We greatly appreciate the Subcommittee's leading role in enacting MACRA given the law's potential to improve physician practices and patient care. The AMA remains committed to helping physicians and CMS understand and best implement MACRA to improve quality reporting and develop new APMs. We look forward to continuing to work with the Committee, Congress, patients, and regulators to ensure a successful start to the new MIPS and APM programs.

Mr. PITTS. The Chair thanks the gentlelady and now recognizes Dr. Bailet, 5 minutes for his opening statement.

STATEMENT OF JEFFREY BAILET

Dr. BAILET. Chairman Pitts, Ranking Member Green, and distinguished members of the Energy and Commerce Subcommittee on Health, thank you for the opportunity to testify on behalf of Aurora Health Care, the largest private employer and the largest integrated healthcare delivery system in the State of Wisconsin.

I am Dr. Jeffery Bailet, co-president of Aurora Health Care Medical Group and one of the largest multispecialty medical groups in the Nation.

As an otolaryngologist head and neck surgeon and medical group co-president, I am responsible for co-leading 2,600 physicians and advanced practice clinicians who provide care to 1.3 million unique patients.

Aurora's diverse delivery system includes several rural community hospitals, urban hospitals, a psychiatric hospital as well as Aurora St. Luke's Medical Center, the State of Wisconsin's largest hospital.

Thank you for extending this opportunity to speak on behalf of MACRA. I am pleased to be a leader of this transition not only as a medical group physician leader but also as co-chair of the physician-focused Payment-Model Technical Advisory Committee, or PTAC.

I applaud Congress, particularly this committee, for incorporating the PTAC in MACRA as an advisory panel to consider physicians and other stakeholders' proposals for new models of high value care.

I am also fortunate to serve as chair-elect of the American Medical Group Association representing medical groups and health systems including some of the Nation's largest most prestigious integrated delivery systems.

I am pleased when standing in front of the physicians I support or speaking with physicians across the country that there's no longer debate about the need to transition to value-based care delivery.

Shifting the culture of the healthcare community to the importance of value is a huge accomplishment and our patients across the country will benefit. It is equally important, however, that regulators appreciate the need to proceed cautiously during this transition.

Many physicians are in various stages of readiness for a value-based payment system. There is and will continue to be a significant learning curve as providers begin to take on financial risk.

When implementing the regulations for MACRA's payment systems, CMS should recognize that the healthcare system will need time to adapt and learn how to function in this new payment environment. Providing an incremental approach that includes flexibility and rational exposure for financial risk will be vital in ensuring a successful transition to value-based payment.

Congressional oversight of this process is needed and welcomed. Physicians, whether they are in small group practices, larger multispecialty medical groups or high-performing integrated delivery

systems must make significant investments to succeed in a risk-based environment.

For example, Aurora launched a predictive analytic pilot focusing on preventing hospital admissions and readmissions. Using a predictive analytic tool, Aurora was able to stratify a population of heart failure patients who had an 80 percent or higher likelihood of needing to be hospitalized as a result of their disease.

We then redesigned our care approach using health coaches, frequent proactive outreach and engaged patients to take active ownership of their treatment and health status. This effort helped Aurora reduce our congestive heart failure-related admissions by 60 percent.

To help solo and small group practices participate, Aurora is developing clinically integrated networks across our geographic area. For example, we helped found About Health, a clinically integrated network that enhances clinical quality, increases efficiency and improves customer experiences, providing access to care for about 94 percent of Wisconsin's population.

About Health is an example of how partnerships in Wisconsin between integrated delivery systems and small group practices can create a culture of learning and fostering of best practices to improve quality of care and reduce costs. This effort also helps small groups and solo practices that wish to maintain their independence the ability to do so.

It is vital that CMS continues to engage the stakeholder community. The healthcare provider community is eager to share its insights with CMS and to date CMS is making a sincere effort to engage.

I encourage CMS to build upon these efforts as value-based parameters are being clearly defined. MACRA represents a realistic opportunity for healthcare providers to improve the quality of care while reducing healthcare spending.

High-quality patient outcomes is paramount and the continuous improvement initiatives and redesigned infrastructure we have implemented at Aurora can serve as a guide to other providers.

Also, Aurora seeks out better, more effective ways to deliver care from our colleagues around the country. Moving forward, Aurora is prepared to fully participate in the development of new risk-based payment models that have the potential to improve patient care and bend the cost curve.

Thank you.

[The prepared statement of Dr. Bailet follows:]

Statement of
Jeffrey Bailet, MD
President
Aurora Health Care Medical Group
on
Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms
before the
Subcommittee on Health
of the
Committee on Energy and Commerce of the U.S. House of Representatives
April 19, 2016

Chairman Pitts, Ranking Member Green and distinguished members of the Energy and Commerce Subcommittee on Health, Thank you for the opportunity to testify on behalf of Aurora Health Care (Aurora), the largest private employer and integrated health care delivery system in the state of Wisconsin with 31,000 employees. I am Dr. Jeffrey Bailet, Co-President of Aurora Health Care Medical Group, one of the largest multi-specialty medical groups in the nation. As an Otolaryngologist - Head & Neck surgeon and medical group co-president, I am responsible for co-leading 2,600 primary and specialty physicians and advanced practice clinicians, who provide care to nearly 1.3 million patients a year at 180 clinic sites and 15 hospitals across eastern Wisconsin and northern Illinois. Our physicians, advanced practice clinicians and other caregivers provide a wide variety of care across 90 communities, including large cities with hundreds of thousands of people to rural towns with populations of less than a thousand. Aurora's diverse delivery system includes several community hospitals located in rural areas, urban hospitals, a psychiatric hospital, as well as Aurora St. Luke's Medical Center, the state of Wisconsin's largest hospital with over 700 beds, which is home to world class cardiovascular and neuroscience programs providing complex neuro, heart and vascular surgical and minimally invasive care.

Thank you for extending this opportunity to me to speak on the important topic of reforms included in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). I appreciate the opportunity to speak to this noteworthy congressional policy achievement and I am pleased to be a leader in this transition toward a value-based Medicare payment system not only as a medical group physician leader but also as Chair of the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The PTAC was created by MACRA as an advisory panel appointed by the Comptroller General to consider physicians' and other stakeholders' proposals for new models that foster high quality, high value health care. The PTAC will then advise the Secretary of

Health and Human Services (HHS) regarding what payment models are likely to meet HHS' goals of better health and smarter spending. I am also fortunate to be serving as chair-elect of the American Medical Group Association (AMGA), which represents medical groups, health systems, and other organized systems of care, including some of the nation's largest, most prestigious integrated delivery systems. Today, one in three Americans receives their care from an AMGA member organization. My comments today are on behalf of Aurora and reflect our understanding of how to foster a culture that embraces quality and engages patients on their terms. We believe our experience in providing comprehensive care to a diverse population over an extensive geography and expertise as a high quality provider have afforded us with the insight to offer testimony today on how best multi-specialty and integrated delivery systems can prepare for the reforms included in MACRA.

With the enactment of MACRA, physicians and the larger healthcare community recognize and are preparing for a Medicare payment system that is transitioning away from an unsustainable fee-for-service model based on the volume and intensity of services provided to one that is value based, patient centered and accountable. Aurora and likeminded medical groups, physician practices and health systems appreciate that this transformation of care delivery is pressing both to enhance the quality of patient care and to address the financial challenges inherent in our current volume based system. It is equally important, however, that regulators appreciate the need to proceed cautiously during this transition. Medicare largely has been based on fee-for service payments since its inception and many physicians are in various stages of readiness for a value-based payment system. While systems such as Aurora and our physicians have early experience with value-based payment structures, there is and will continue to be a significant learning curve as providers begin to take on financial risk. When implementing the regulations for MACRA's payment systems, whether it is for the Merit-Based Incentive Payment System (MIPS) or an Alternative Payment Model (APM), CMS should recognize that the healthcare system will need time to adapt and learn how to function in this new payment environment. Providing an incremental approach that includes flexibility and rational exposure to financial risk will be vital in ensuring a successful transition to value-based payment. Congressional oversight of this process would be needed and welcomed.

Aurora experienced the importance of this learning curve with our decision to participate in the Medicare Shared Savings Program (MSSP). Although we no longer participate in the program, we did not do so to avoid assuming risk. Rather, we elected to no longer participate in order to reassess our own infrastructure and care processes so that we eventually could reapply and be in a better position to succeed. Time is needed to review what does and does not work, and how to position our system for success in such a program. In our case, we needed to further integrate a newly acquired physician practice, with its own unique Tax Identification Numbers (TINs), into the Aurora structures and processes, including transitioning from paper to an electronic health record, before proceeding with the MSSP. Based on these lessons, we are preparing to submit an application to participate as a Track 3 Accountable Care Organization, which

allows for two-sided risk. This would not be possible without taking the time to assess our situation and adequately prepare for the new risk-based environment.

Physicians whether they are in small group practices, larger multispecialty medical groups or high performing integrated care delivery systems, must make significant investments to succeed in a risk-based environment. This includes implementing information technology and electronic health record systems, migrating to team-based care delivery, redesigning care processes as well as the physical care environment, and, perhaps most importantly, developing highly engaged physicians and caregivers to embrace and thrive in a culture that emphasizes continuous quality improvement and is focused on exploiting practice and process efficiency enhancements at every step of the care continuum.

In addition, it is simply not enough to purchase an electronic health record (EHR) system. The data collected by these systems must be analyzed and interpreted in ways that, when reflected back to physicians and their care teams, it's meaningful and actionable allowing care teams to deliver the highest quality of appropriate care that delivers the most value to patients. This also ensures best practices, once identified, can be disseminated across the entire healthcare system through shared learning and collaboration.

For example, Aurora provided well over 7 million patient visits in 2015. While data is constantly collected, extracted and analyzed, Aurora recognizes that this data is simply not a statistic on a particular disease or condition, but that each data point represents a life of someone in our community. Our culture, which is based on quality, appreciates the need to not only protect this data, but analyze it so it can help inform clinical practice decisions that result in the best possible outcomes for our patients. Based on this approach, for example, Aurora launched two predictive analytic pilots focused on preventing hospital admissions and readmissions for two patient cohorts, one with congestive heart failure (HF) and the second with chronic obstructive pulmonary disease (COPD). Using a predictive analytic tool, Optum One, Aurora was able to identify and stratify a population of HF patients who had an 80% or higher likelihood of needing to be hospitalized as a result of their disease within the upcoming six month period. We then redesigned our care approach to this cohort of patients using health coaches, frequent proactive outreach and engaging patients to take active ownership of their treatment and health status. A similar approach was utilized for the COPD patient cohort. This effort helped Aurora reduce our congestive heart failure related admissions by 60% in a 2 year period comparing the same HF cohort 1 year before and 1 year after intervention, a 20% reduction in COPD related admissions for the COPD cohort and a 20% reduction in all cause admission rates for both HF & COPD patient cohorts. Equally important, our interventions improved their health risk status making it less likely that they would need higher levels of care going forward. Aurora received national recognition for this work receiving the 2015 Optum & AMGA Award for Innovation in Population Health and has formed a partnership with the AMGA to share these learnings with other physician groups across the country.

Effective, coordinated care management using a team-based approach along with mining and converting large amounts of electronic health record data into actionable care delivery interventions to populations of patients with similar diagnoses is essential to providing care under MIPS or an APM. While MACRA recognizes the need for effective EHR use, such investments in health information technology are only the starting point. Aurora, for example, recently invested $300 million in its care management infrastructure including a complete change out of our EHR system. While significant, this is more akin to a down payment or starting point than a turn-key solution. Another example of the critical importance of team-based care is the transitional care program Aurora Health Care has developed aimed at preventing readmissions. Each Aurora hospital has transitional care nurses that follow patients that are at a high risk for readmission. These nurses contact the primary care physician prior to discharge alerting them to fact that the nurse will be assisting with the patient's transition to home. They also monitor the patient for 30 days after discharge. This follow up includes in-person in home visits and phone calls. The nurse also works with the primary care office after discharge to help make any other care connections during those 30 days. The nurse documents in the EHR so that the care provided is visible to all who are caring for the patient. Over 70 % of patients discharged in this program have a follow-up appointment with their primary care physician with-in 7 days and this percentage continues to increase. The role of the transitional care nurse further emphasizes the importance of the need for physicians to partner with their care teams to most effectively manage populations of patients.

While Aurora has invested significant resources into care management and health information technology infrastructure, these investments will be challenging for solo and small physician practices. In rural communities, physicians in small practices with limited resources will need continued support to succeed in the transition to alternative payment and value-based delivery models. Congress should be commended for making special educational opportunities available for rural practices. MACRA provides for technical assistance to MIPS eligible professionals in small practices and practices in health professional shortage areas (HPSAs) and allocates $20 million annually from FY 2016-2020 for CMS to execute this program. While CMS has not made any funding opportunity announcement or given any indication as to when it intends to do so, Congress was forward thinking in creating this program; and, as CMS implements MACRA, this funding program will be an important mechanism to make sure rural areas and small practices are not left behind.

In the meantime, to help solo and small group practices participate, Aurora is developing clinically integrated networks (CINs) across our geographic area. In 2014, for example, we helped found AboutHealth, a clinically integrated network that enhances clinical quality, increases efficiency, and improves customer experiences through shared practices. This network provides access to care for about 94 percent of Wisconsin's population and serves patients in Illinois, Iowa, Michigan and Minnesota. By creating a strategic partnership with other high performing healthcare systems in our region, we are able to build upon and advance clinical quality, efficiency and patient experience. For example, in 2015 and 2016, AboutHealth is focusing on the following

quality initiatives: Diabetes Mellitus type 2; Central Line Infections; Post-Operative Mortality; Patient & Family Centered Care; End of Life Care/Advance Care Planning; Total Knee Arthroplasty; Back Surgery; and, Ischemic Vascular Disease.

All work done on these initiatives is not only implemented by the physicians in the member organizations, but also the physician networks of these member organizations. As a result, smaller practices have an opportunity to collaborate with larger systems to improve patient outcomes. AboutHealth is an example of how partnerships in Wisconsin between integrated delivery systems and small group practices can create a culture of learning and fostering of best practices to improve quality of care and reduce costs. This effort also helps small groups and solo practices that wish to maintain their independence from a larger system, such as Aurora, the ability to do so. By clinically integrating with other providers, we have the ability to collaborate on key aspects of patient care and avoid consolidations that are made out of financial necessity. Even with this support, however, practices in small and rural communities will need additional support and flexibility to successfully transition away from the fee-for-service to new payment and delivery models.

To truly succeed in a risk-based environment and fully benefit from clinical integration, federal payers such as Medicare and commercial insurers need further alignment. MACRA creates an opportunity to facilitate improvements in this area. For example, quality measurement reporting and data requirements should be standardized across payer type. This avoids needless duplication and would streamline quality measurement reporting efforts.

One of the ways Aurora is preparing to succeed in MACRA implementation is by making substantial investments in improving and enhancing our hospital outpatient departments (HOPDS). Aurora's HOPDs stand on the front lines in delivering integrated and coordinated high-quality care in settings that are most appropriate and convenient for our patients. These unique capabilities have positioned HOPDs to play a leading and effective role in helping to transform America's health care system to a value-based system where delivery models will need to be heavily predicated on coordinated, patient-focused and team-based approaches. We encourage Congress to move swiftly to reduce the uncertainty over Medicare reimbursement policies for HOPDs currently under development created by the Bipartisan Budget Act of 2015, which only creates disincentive for these facilities to participate in any risk-based alternative payment models where they face further financial downside.

MACRA envisions a system of care that spans facilities and provider types and is focused on the aggregate quality of care that the patient receives. In short, it facilitates breaking down many of the silos that have dominated healthcare for too long. While CMS has introduced a number of risk-based initiatives, the agency is still internally structured for and regulates by silos of care based on setting. Furthering the effort to reduce compartmentalization in the healthcare delivery system must be accomplished to accelerate MACRA's success but may be hindered until the regulatory environment and CMS' organizational structure evolves further.

As the regulations for MIPs and APMS are developed, it is vital that CMS continues to engage the stakeholder community, including provider groups, patient advocates, specialty societies, medical associations, payers and others. The healthcare provider community is eager to share its insights with CMS and to date, CMS is making a sincere effort to engage with the healthcare community stakeholders. I encourage CMS to build upon these efforts and activities taking into account stakeholder concerns, experiences and expertise as value-based parameters are being more clearly defined and implemented for patients. Ultimately, the outcomes resulting from the regulations that CMS implements will only be enhanced by the input from stakeholders within the healthcare community as the regulations are under development. I look forward to continuing to engage with CMS in the future as their work continues.

While a predominant focus of MACRA has been on primary care, it also is important to engage the specialist community where considerable healthcare resources are consumed. These physicians and their specialty societies are actively developing and deploying successful alternative care initiatives that are enhancing care quality at more affordable costs. Specialists are eager to play a larger role in facilitating the transition from volume to value-based care delivery and will serve a vital role in the continuum of care that patients will need going forward as the population ages. New alternative payment models that account for the care specialists provide should be included among the APMs ultimately developed and proposed to CMS for consideration.

While MACRA provides incentives to participate as an APM, there are several actions that CMS can take to ensure full and meaningful participation in the program. As it is developing the regulations for APMs, CMS should take steps to ensure providers have full access to claims data, data exchange formats are standardized, the risk-adjustment and physician attribution methodologies are improved, and patient engagement activities are supported. Claims data provides the most accurate and actionable information on the care we provide and how we can improve our processes to the benefit of our patients. Standardizing data exchanges creates continuity across the healthcare system and avoids unnecessary delays with data transfers and analysis. Appropriately accounting for the risk of a patient population is essential for providers to successfully take on risk and financial responsibility. Regarding patient engagement, CMS must recognize and account for the variety of patient engagement activities that a system such as Aurora may use to connect a provider to a particular patient. This can include virtual care, which may be new for patients. Telehealth also is an important tool in reaching patients and helping to manage their care. These systems need to be recognized and incorporated into APMs. With these changes, doctors will interact with the patients in ways that may be new and unfamiliar to them. It will be important that patients assume more ownership of their care; however, as providers and payers we must ensure they have the means and ability to do so. CMS also may wish to review AMGA's recent survey of its members on their ability to transition to risk. The report, which I have attached to this testimony, explored how multispecialty groups and integrated delivery systems are preparing for the transition to the risk-based environment.

MACRA represents a realistic opportunity for healthcare providers to improve the quality of care while reducing healthcare spending. High quality patient outcomes is paramount and the continuous improvement initiatives and redesigned infrastructure we have implemented at Aurora can serve as a guide to other providers as they transition to value based care delivery. In turn, Aurora appreciates the importance of providing value and quality care to our patients and we continually seek out better more effective ways to deliver care to our patients from our colleagues around the country. MACRA provides a viable framework to achieve these goals. We believe our experience in care coordination and care process re-design demonstrates our willingness to participate in a risk-based payment system. Moving forward, Aurora is prepared to fully participate in the development of new risk-based payment models that have the potential to improve patient care and bend the healthcare cost curve.

Mr. PITTS. The Chair thanks the gentleman. Thanks to each of you for your opening statements. We'll now begin questioning. I'll recognize myself for 5 minutes for that purpose.

I'd like to begin with the APMs and then go to MIPS and we only have 5 minutes so we'll just go down the line. Dr. McLean, what can physicians do right now to position themselves to succeed under an APM?

Dr. MCLEAN. Well, I think an APM is a larger entity. For either of the two, let me say, to start off I think physicians need to realize that they need to have a good electronic records system.

Most of what we're dealing with now is really dealing with lots of data and a lot of physicians and smaller practices have not had to do that.

They've had to start to if they've been keeping up with PQRS and some of those things, but you may know that PQRS I think recently showed that something like 50 percent of physicians in the country didn't even report.

It just wasn't worth the effort to them. They'd rather take the financial hit than kind of put the systems in place to do so. Now with some of these things I think there's a lot more motivation for physicians and physician groups to actually do that.

So the first thing they need to do is make sure they have an electronic records system that's able to do a lot of the things that are required here and simplistically.

Mr. PITTS. All right. That's good.

Dr. Wergin, what can physicians do right now to position themselves to succeed in MIPS?

Dr. WERGIN. They can go to our Web site and look at the resources we have.

But for a starting point is recognize quality measures we hope that can be standardized and the collaborative quality measures will be measured and report to PQRS. You need to be a meaningful use provider of electronic health records, which can be challenging.

In my own practice, I made it on the 90th day in the last few hours. I had to call two patients to call me with a question, which was hard because I practice in a Mennonite community who don't have TVs or radios and they don't have computers. So I had to find some non-Mennonites.

You need to do that, and we recommend to our members to move towards the patient-centered medical home. In the MIPS or eventually an alternative payment model we feel that's where you need to move.

Even under MIPS on the fourth criteria you'll get full credit for that, and we believe that's a better delivery of care.

Mr. PITTS. Thank you.

Dr. McAneny, as you may know, this is our second oversight hearing on MACRA even before the proposed rule and this committee will continue to be vigilant in our bipartisan oversight to ensure that MACRA is a success.

Can you speak from both your organization's perspective and that of a physician of why oversight is important and the message you believe it sends to the physician community?

Dr. MCANENY. Thank you, Mr. Chairman, for that question. I think it's a very important one. The change in the opinions from

CMS that we are now going to have a partnership with physicians to move forward in creating alternative payment mechanisms is probably the most important change that we've seen for a while.

As a practicing physician now I have the opportunity to have Medicare payment reflect what I actually do for my patients to free me from the face to face required encounters and let me actually create a system that will manage patients more effectively provides an incredible opportunity.

From the AMA standpoint, we are working very hard to continue to work with CMS. We have provided information at their request for information. We've had listening sessions with CMS.

We continue to convene specialty societies from all around the country to be able to work with their own specialty to try to create alternative payment methodologies that will work in that specific specialty and we recognize that in different communities with different needs and different levels of resources it will take a different method to provide these alternative payments for them.

So we really have worked a lot with our physician guide to alternative payments, with our Web site offerings, our Steps Forward program to teach physicians what they need to know right now as they prepare and we very much look forward to seeing the proposed rule.

Mr. PITTS. Before I go to Dr. Bailet, how would you characterize the general physician's knowledge on the repeal of SGR and the passage of MACRA?

Dr. MCANENY. Well, I think the general physician is thrilled to have the SGR repealed and to have that taken out from the sword that's hanging over our heads.

The average physician has—well, there's a huge variation in the amount of information about MACRA. People know that it's there but they don't quite know how it's going to apply to them yet. So all of the specialty societies have their work cut out for them.

Mr. PITTS. Thank you. Thank you.

Dr. Bailet, you note the importance of engaging with the specialist community in the development of APMs. Can you elaborate on where you see growth potential in the future for specialists playing a bigger role in new care delivery models?

Dr. BAILET. Yes. Specialty care, being a specialist myself, they have a lot of influence on some of the care that's delivered that has a higher price tag and the specialists that I talk to around the country are very actively engaged in trying to influence efficiencies and care delivery and they're very sensitive and aware of the treatments that they're offering and the cost associated with them.

Again, it's a learning curve so the physicians are becoming more familiar with the costs and essentially the end product of the care they deliver and it is a partnership. It is no longer silos of primary care and silos of specialty care.

In order for us to be effective and efficient we need to work together as a team and it's not just physicians, it's also advanced practice clinicians. It's nursing. It's your care team. That is the only way we're going to maximize the potential of the health system and deliver the care the patients deserve at the expense and cost that is rational that will carry us forward.

Mr. PITTS. Thank you. My time has expired.

The Chair recognizes Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

Again, I want to thank our panel and you each represent different specialties and I just want to appreciate you taking your time and away from your practice.

My question of each—what are you instructing your members to do to prepare for the transition whether under MIPS, fee for service or the alternative payment methods?

Dr. McLean.

Dr. MCLEAN. Well, I think the testimony gets into a little more detail but as other organizations the ACP has been working very hard to put resources together that are available online as well as in multiple publications.

The ACP has worked for years on trying to help internal medicine and its subspecialty practices kind of do the right thing through the practice organization. So for a number of years, there's been stuff on their Web site and resources about becoming a patient-centered medical home and on how to pick out health records something called EHR partners. So there are resources available to try to make it easier for physicians to go through some decision making on some of those things.

As we now have MIPS and APMs we're taking some of those resources that were already there and developing them into something that's really germane to what we're talking about now so the physicians can have help making the decision. You know, do I—am I in an organization that's going to qualify as an APM or do I need to kind of go the MIPS path because that's kind of one major fork in the road that people or that physicians will need to decide.

Mr. GREEN. Thank you.

Dr. Wergin.

Dr. WERGIN. Well, I think it's—I hope this is on—I think it's a challenge for our diverse group. We go from rural communities like mine of 2,000 people up to large healthcare systems. So we have to go where our members are.

But I think in the long run it still comes down to comprehensive coordinated care. That's what we can provide to an APM. When I go out to States, I am kind of amazed. A lot of people have heard of MACRA but not a lot of details. So we try to begin the education. They're holding back.

We said now is the time to act and move forward to, you know, to being the transformation of your practices to prepare for MACRA.

So we have tools on our Web sites. When I'm there talking to them for the smaller practice virtual groups or the TPNs or some of the assist granted money that that way can do it to band together and create the infrastructure to keep them alive.

They're important and when they complain I said, do you want to go back to 20 percent cut. In my practice, it's 35 percent Medicare. It would have probably been the end of my practice. I couldn't boutique it. They're my neighbors.

I can't say I can't see Medicare anymore. Couldn't anyway from a business plan. So we want to prepare all our members in whatever form their practices take and give them the resource to prepare for it.

Mr. GREEN. Dr. McAneny.

Dr. MCANENY. Thank you very much.

Again, we start out with the idea that we need to have a tool and we've created one that will help physicians try to learn whether they're better off in MIPS or in MACRA or in the alternative payment model of MACRA.

We also are working very hard to make EMRs—electronic health records—into the functionality that they need to have.

One of the very important things that all practices are going to need is to be able to have the date both their own internal data and claims data back from Medicare so that we know how we're doing. And it doesn't help us at all if we get data six months or a year later. How can you change when that happens? You've already lost a year.

So we're trying to work with CMS to modify the electronic health records meaningful use processes so that those become tools that really help us as we engage in patients and not just data collection instruments and we will continue to work, as the others have mentioned, with educating our members as to what their options are, how to get prepared for this, how they can look at creating quality measures.

The other thing that's very important that I think the AMA is doing is working with multiple specialty societies to create quality measures that are not only good measures but are actually useful as they work to transform their own practices.

Mr. GREEN. OK. I only have a few seconds left.

Dr. Bailet, I was just wondering—you know, Congress subjected physicians for 18 years to the SGR and uncertainty. Electronic medical records is such a vital part of what we're doing.

Your accountable care organization, Aurora, is redesigning several approaches to patient care, especially in the area of heart failure and COPD. Can you describe these and also if you're suggesting in your practice and your other physicians anything different than what the other specialties make?

Dr. BAILET. Well, I'm answering the question from the perspective of a medical group leader and I will say that there is anxiety amongst the physicians that I support mostly from not knowing exactly what the rules are going to be, how this is going to play through their practice at the individual level and it behooves us as leaders to support them and to help them understand that we're here—we're here for that support and unburdening their practice.

I want to be clear: The electronic health record is the foundation, but it is nowhere going to get us where we need to be if we cannot take the data, analyze it and reflect it back to the practice in ways that are actionable, that are actually going to impact patient care, then it will just be noise that's out there and the physicians will get continually frustrated and they won't be able to do what they need to do for their patients.

So we have to develop a culture of learning, a culture of continuous improvement and to maximize the data in a way, as I said, that it becomes actionable at the patient level. And that is not a small initiative and undertaking. I want to be clear that yes, you can buy an electronic health record, yes, you can deploy it and yes, you can teach your physicians and clinicians to use it. But until

you develop the infrastructure that can analyze it, compartmentalize it, can stratify your patients where you're going to need to deploy your resources in the most critical areas, you're not going to be able to provide the kind of care at the cost that is going to make this successful.

So I just want to caution that it's going to take time build all that infrastructure in and my concern, and maybe that's too strong a word, but my cautions is that we cannot move too quickly.

I know there's a pressing urgency to move forward and I respect that. But I also think if we go too fast and we strip out the physicians who are already struggling with burnout—one of my colleagues mentioned that today—this could tip things out of balance and that would take something as wonderful as MACRA and essentially harm its ability and its effectiveness and I really don't want that to happen.

Mr. GREEN. Thank you, Mr. Chairman. Thank you.

Mr. PITTS. Chair thanks the gentleman. I now recognize Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman, and I hope our friends at the press table were paying attention to that discussion of Dr. McAneny and Dr. Bailet—that you all—I mean, that was some of the most optimistic forward-looking stuff that I've heard. The ability to use predictive analytics, the ability to use data in real time, not 2 years later—this is what doctors want to do and the thing that used to bug me about pay for performances I never drove to work in the morning saying, boy, I hope I'm average today.

No, you go to work every day and do your best work and you're talking about why don't we make things so that they can provide doctors the platform to do their best work and that's enormously optimistic.

Dr. Bailet, I'm like you. I mean, I get to go talk to doctor groups all over the country. I recognize that most of the people in the room are my age or older and most of them, if they're not burned out, they're very close and by the time I finish my talk about what we're going to do in their practices they're checking their retirement plan to see how—you know, how many more days they have to work, not how many more years.

So this is important. We all recognize we have a personpower problem—manpower, womanpower problem in health care, especially in our physicians and we run the risk of making it worse. And this is one of the things that was so important to me when we tried to reform this.

I think, Dr. Wergin, you said—you used the phrase it takes the joy out of practice, and I've used that phrase on the floor of the House. Nothing pulls the joy out of the practice of medicine like realizing your Congress is going to whack you off at the knees December 31st every year for, what was it, 17 years.

I mean, that is—that is a joy-killing exercise if there ever was one. So, again, this is an optimistic hearing today and it's forward-looking hearing and I'm grateful for that.

Dr. McLean, on the—on this wonderful brochure that—is this yours or is it Dr. Wergin's? Dr. Wergin. And, you know, unfortunately we don't have this where everyone can see it. But, you know, if you just run through your physician payment time line

that you've got over there on the—on the right hand side, OK, the doctor says, I'm just not going to do a darn thing—I'm sick of Congress, I'm sick of rules, I'm sick of CMS—I'm not going to do a darn thing.

Well, actually you might wake up in 2019 and realize oh my gosh, I got a 4 percent ding. Now, you didn't get a 27 percent ding so that's an important point right there but you got a 4 percent ding and you could have gotten a 4 percent bump if you'd just done a little.

So the important thing—the message here is for those people who are so frustrated they will not lift a finger until 2019 and then they look across the hall and say well, that guy got a 4 percent bump and I got a 4 percent ding—what do I have to do so I'm in the bump and not the ding group, you can actually start catching up then.

And the folks at Legislative Council and Congressional Research Service and CMS referred to this as everybody gets an A. Well, it's not quite that simple but we wanted it to be simple and we wanted there—and I think I certainly recognize that there was so much frustration out there that, OK, you come at me with a hundred new PLAs—that's three-letter acronyms—I'm not—I'm not there. I'm not going to participate.

In fact, I'm going to retire—I'm getting out. But if they don't get out and they look around in 2019 I can go from the ding to the bump group and it is not that hard. Many of the things I'm already doing.

I might already be emailing a patient. I might already be involved—engaged in performance practice enhancement activities and so be eligible for that.

So thank you for making that kind of—I think it's just critical that doctors do understand that yes, a lot of this stuff is really hard in the healthcare policy but some of it's not and some of it makes sense.

Your Mennonite stuff doesn't make sense with a meaningful use but some of it makes sense. I will also confess to you I used to consider myself basically a medical home for my patients when I was in practice and I was the medical home until the wizards at CMS with administrative pricing decided I wasn't worth it and didn't pay me for it anymore.

So I ran for Congress and that medical home is now abandoned. But it is that concept—let's do the things for people that actually facilitate what we need done.

And Dr. McAneny, you talked about physician leadership and, you know, that is so critical and this leadership has to come from within medicine itself. It's not going to come from a consultant. It's certainly not going to come from CMS. God knows it's not coming from the Congress.

It's got to come from inside medicine itself. So think you for your efforts in making certain that your constituent members understand that and I'll leave my last second for you to respond to that if you'd like.

Dr. MCANENY. If I may, Mr. Chairman.

Mr. PITTS. You may proceed.

Dr. MCANENY. The point that you made about we want everybody to get an A is the most important point because we can't afford to leave any physicians behind when we are facing a physician shortage. We need to find a path forward for everyone and we need to understand that we're not going to get it right with the first set of regulations.

But we need to make this a rapid-learning process where physicians can try something, not be penalized for it but to have CMS as a partner with all of the specialty societies they work with to be able to move forward and come up with something that better serves the patients of the country.

Mr. BURGESS. Great. Leave no doc behind, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman, and thank you all very much for being here today. It's great to hear from folks on the front lines who are taking care of our families and neighbors back home.

You all sound like many of the doctors and physicians that I interact with back home in the Tampa Bay area. They really are enthused about the opportunities of practicing medicine and focusing on value over volume but are a little bit concerned about the transition ahead. So we're really going to need your help and advice as we go along.

First of all, for all of you just a quick answer. Is CMS being proactive with you? Are they open to your comments? I know it's still fairly early in this. Are they—and do you believe they have the expertise to work with you to develop these alternative payment methods?

Dr. MCLEAN. So thank you. Yes, absolutely. I think that from the get-go since they rolled out the first, I guess, RFI last fall and the ACP—at least I can speak for them—sent in I think 40 pages of comments and question/answers and received tremendous feedback on that. There's been an ongoing dialogue between our organization and people at CMS, and then with the second round of questions in the last month or two. So as with everyone else, we're clearly very anxious to see what the final rules are going to be because I'm sure it's not going to be perfect.

Nothing ever is. But I think that thus far CMS has proven to be a very willing participant in conversations as is willing to listen and that's critical.

Ms. CASTOR. Do you all agree with that?

Dr. WERGIN. Yes.

Ms. CASTOR. OK. Great.

Dr. WERGIN. I would say the same, and our response is we feel like they're listening and we respond and try to be very specific and positive in what we would suggest and a key thing is keep it simple and reduce our administrative burden.

Ms. CASTOR. And Dr. McAneny, you—in your testimony you raise some points. The population all across the country is not the same and you talked about how these alternative payment methods and MIPS are going to have to be tailored for populations.

How do you think that's going to work in areas of great health disparities? How do we ensure that doctors are available to take on those complex cases that are going to be especially difficult? You

wouldn't want medical professionals to be—to have a disincentive for taking care of those populations.

Dr. MCANENY. Well, I think that's very important to avoid any of the disincentives. We need to make sure that as we do quality measures or performance measures that they are very useful for each individual practice.

Making a physician take time away from the patients they serve to answer questions and fill out data fields that have nothing to do with what they do all day takes away a valuable resource of physician time.

What we are trying to do at the AMA is to make sure that we have a variety of tools and recognize that this is going to have to come from the bottom up with CMS and Congress as a partnership rather than as a punitive entity so that when a physician says this would be what would benefit my patients we're hoping that when the proposed rule comes out there will be enough flexibility in that to allow the creativity of physicians to be tested and, if it doesn't work—and not all the models will work—we need to have the ability then to go back and change things without imposing penalties that threaten the existence, particularly of those rural practices and under served areas who are often hanging on by their fingernails now.

Ms. CASTOR. I agree, and I think we're going to have to be especially mindful.

Dr. McLean, we have a very serious issue with graduate medical education and this arbitrary cap, I think, after the SGR the Congress, with all of your help, we have got to tackle this doctor shortage and focus on GME as well. But setting that aside, are we training the doctors of tomorrow to be ready for this kind of practice?

Maybe we have been all along and then the SGR and volume over value took its toll but what do you see as the future of medical——

Dr. MCLEAN. Interesting question. I think in the last several years when you look at where graduating medical students go into residency there has been an uptick in primary care in medical fields.

Until that time I think some of the finances of medical school debt and what potentially am I going to go into as a practice situation—am I going to—you know, my income is going to be related to what debt I have to pay was a big issue for I think a lot of physicians and helped drive physicians away from some of the primary care specialties which tend to be lower paying in aggregate.

I think that the SGR being removed takes that cloud away somewhat. Is it going to drive, you know, a real difference I don't know yet. At the same time, I think people who go into medical care now are going into it really for the right reasons.

They know that it's a complex field and it's remarkably complex and they want to take care of patients, and in some cases I think there's much more education on systems and big data and how do you fix populations. Population health is really a new concept in the last 5 or 10 years and I think there's a bit more education about it at medical schools. So I think that they have a better sense of what they're going to need to deal with going forward.

Ms. CASTOR. Thank you very much.

Mr. PITTS. The gentlelady's time has expired. The Chair now recognizes the vice chair of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you. Thank you all for being here, and I met with a group—a physician group yesterday and they were asking a lot of questions about alternative payment models and so forth, and my point to them was if—you know, if a few dozen people or so sit in Washington, DC in a room and design all of this it's not going to be successful. It's got to be from physicians up—from practitioners moving up so that we can take it into account.

So this panel is important and I appreciate the opportunity to have you guys before us and eagerly look for your input as we move forward because that's how it's going to work.

But we're also eagerly awaiting the proposed rule but I want to know about the proposed rule what are you guys most excited about? I'll just open it to the panel. I'll start to my left and start with Dr. McLean. What are you the most excited about by the opportunities that MACRA offers?

Dr. MCLEAN. You know, I think to echo what Dr. Bailet said, I think the idea that we can take a lot of data that's been floating around out there that we've been collecting in many ways and actually make it actionable incentivize is extremely exciting.

There's a lot of information on clinical guidelines that come out of there. Sometimes they changed from week to week, depending upon the topic and the organization that puts it out there.

But physicians are confused—do I need to follow this or not. But clinical guidelines are a part of clinical practice. There are clinical measures that have been out there.

Some are good, some are bad. How do we use them? If those kind of elements of clinical practice and trying to improve how well we can deliver high-quality care can be systematically kind of put into a situation where doctors are incentivized to use this data well.

The electronic records that to some extent are almost a necessity are configured to use those elements well we can make a part of daily flow—work flow—and patients' care will be better and more reliable and safer and physicians will be happier because they're not checking off all these boxes just because CMS told them to. There's actually a rhyme behind the reason and it's been missing that up until now, I think.

Mr. GUTHRIE. OK. Do you want to add? That was a pretty comprehensive answer but we'll—go ahead, I'll let you guys——

Dr. WERGIN. I would just say personally and for my members we're excited about the opportunity to value primary care appropriately which hasn't always been done and it was mentioned we need more primary care family physicians across this country in any setting—urban, rural, under served—and that's an opportunity that finally moved us up to the plate. We're excited about transforming our practices to patient-centered medical homes whether they be in the MIPS or APM models because our studies show that the physicians are happier.

They're there to see patients, not click boxes, not try to meet all these arbitrary guidelines or requirements, and I think that's what team-based patient-centered medical home can do.

So I think valuing primary care more appropriately will give us resources to think outside the box, not face to face care all the time—all the other parameters that we can use. So we're excited about it.

Dr. MCANENY. Thank you for that question. Personally what I'm most excited about is that a week and a half ago my practice was selected to participate in the oncology care model, which is one of the, hopefully, alternative payments and we're one of ten practices in the country that's certified as an oncology medical home. So I'm hoping that the proposed rule will come out and say yes, that is an alternative payment.

I'm also very excited about the idea that electronic medical records will become interoperable so I can share data with other people who are taking care of my patients without having to fax records back and forth and to be able to use the alternative payment from the oncology care model to maybe be able to hire a social worker.

I haven't been able to afford a social worker. Or perhaps a dietician to help my patients or nurses to have more time to spend educating patients about their choices.

So I think what I see in my own particular practice will translate very well across the country and the AMA is going to work very hard with all of the specialty societies to find models that can make them as excited about what they're doing as I am about what I'm doing.

Mr. GUTHRIE. OK. So let me ask another question. We'll start with you, Dr. Bailet, and we'll work back the other way this time.

So when we passed MACRA we envisioned it as a means to provide greater flexibility for physicians and not impose new burdens. Can you speak to the current burdens associated with quality programs in your practices and how you believe MACRA can lower the administrative burden while focusing on quality?

Dr. BAILET. I think my colleagues will agree there's so much repetitive reporting, overlap, gaps. It's incredibly burdensome on the reporting today and I'm hopeful that in—you know, hopeful that the legislation will address that going forward.

I think that that's one of the biggest pieces and also how we engage the physicians with the reporting. I mean, there is in my own practice to some degree there is—there are gaps and disconnects where the reporting is a little down field.

It's not direct line of sight. So physicians want to do the right thing and we have to provide the information to them in a way that allows them to make changes that are relevant in the moment.

And I would say that our current system doesn't allow us to do that. I know you changed your question but I had an answer.

Mr. GUTHRIE. Go ahead.

Dr. BAILET. But it's 0K——

Mr. GUTHRIE. Yes, as long as the chair——

Mr. PITTS. Go ahead.

Dr. BAILET. I think MACRA has the opportunity to unleash innovation. We are essentially going to transform the care delivery. This is a very single moment in time where we're going to make an impact and rally physicians and clinicians around giving them

ways and tools to better manage their patients and provide and reflect back to them results that actually make a difference.

And we need to create the aura of desirability at a national level where it becomes group agnostic. The best practices, once identified, need to get pushed out quickly and I think these incentives will help foster that. So that, to me, is one of the most exciting things about the position that we're in now.

Mr. GUTHRIE. Thank you. I do have more questions but I'm out of time so I'll yield back.

Mr. PITTS. The Chair thanks the gentleman and now recognized the gentleman, Dr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman. Interesting panel and interesting discussion. It is nice to hear a fairly upbeat panel in front of us these days and you're at the ground zero for making this whole thing work and I guess our job is to hopefully help you that way.

A question—doesn't matter, Dr. Wergin, I guess—how to the incentives, in your opinion, on MIPS and the APMs align in terms of the dollar value?

Dr. WERGIN. Well, I think one of the things we supplied to CMS is if you base your quality payments or your value-based payments on the old fee for service world, we were relatively under valued. So we hope that they won't use those criteria—the complexity and intensity of visits we have.

But in general, I think we're not afraid to be—step forward and have that comprehensive coordinated care piece that we do and I'd be remiss if I didn't mention quality measures.

When I have diabetics come into my practice and say what should my numbers be, doctor, I have to ask them what insurance do you have because if you're Blue Cross, it's this—if it's United Health Care, it's that.

Huge opportunity for MACRA to say these are evidence-based standardized guidelines. Then I know what the field is like and can get them there.

Mr. SCHRADER. So who decides the quality measures that are—how much do the physicians or other medical providers play into that?

Dr. WERGIN. Well, again, it goes back to the payers and I think CMS has had a collaborative group, said 21, not 165—that's the other thing that can be great.

Usually in my area with six or seven different plans, payers, it's set by the payer and there is physician input in that but they vary slightly, each one. So you can be a prime five-star physician in one and a one-star bum in the other, just depending on where you're at and how they set their parameters.

Mr. SCHRADER. So Dr. McAneny, is there—is there a form right now for medical providers to share in ways to succeed under a MIPS or APM model?

Dr. MCANENY. I don't think we have a—set up a forum for that. But one of the things we're trying to do both through our innovators committee and through the AMA network of physicians working with all the specialty societies is to try to do some rapid learning and bring some of those forward.

Mr. SCHRADER. I think it would be a good idea to make sure folks could share and, you know, hey, I'm on—I'm doing the MIPS thing and here's how I succeed—here's—I'm going APMs and here's a way you could succeed there.

You know, a lot of—to your guys' points these are small business men and women just trying to, you know, keep their practice open in addition to practicing great medicine and so they're going to need some help. Their practice managers, hopefully, would be able to access some of the—some of the data.

Dr. Bailet, with regard to EHR, I mean, I hear a lot of conflicting things when I go back home from my medical community. It's yes, it's really good—we're getting into that interoperability or geez, it's terrible—I can't get my lab report to speak to my physician office, you know, and my—I come from Oregon.

In my State it's all pretty much Epic and so I'm totally confused as to if we're winning or losing on the EHR front. And then to your comment, you know, the feedback to the physician or to the office—maybe it's not the physician, maybe it's the practice manager about hey, you know, I'm reading all this stuff and it looks like if I treat this pancreatic patient this way, based on national data that we've helped supply, is that stuff out there or is that the stuff you're talking about hopefully will come?

Dr. BAILET. Well, I think it's embryonic. I mean, it's coming on but it is not ubiquitous across the system right now. I think that, you know, electronic health records are not perfect and no one has quite figured it out.

Epic, obviously, comes from Wisconsin. We transitioned. We were Cerner's largest client in the United States. We had deployed it fully across our system and we decided after 20 years it did not give us the lift that we needed going forward and we changed it out, $300 million later.

That is no small undertaking and I do believe there's not a CPT code that you can charge for changing out your EHR.

Mr. SCHRADER. Probably not.

Dr. BAILET. But we believed, again, that's just the platform. So, yes, there are predictive analytic models out there and I'm not advertising for one versus the other.

But they're just beginning to demonstrate the power and, again, approaching the diseases that matter. So heart failure, COPD, diabetes—these are the diseases where a lot of funds are being expended on behalf of our patients and I know a lot of our conversation has been talking about the financial piece.

Obviously, that's important. But I think we cannot—we cannot minimize the impact on really transforming patients and what we were able to do at Aurora by changing their health status.

So they were going down a track of outcomes. We were able to take them off that track and improve their health status which, again, that's where the predictive analytic tool provided us the insights to be able to do that. That is significant.

Mr. SCHRADER. Excellent. I yield back, Mr. Chairman. Thank you all very much.

Mr. PITTS. Chair thanks the gentleman and now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman. Thank you for holding this hearing. Thank you all for being here.

I was a healthcare provider before and a heart surgeon, as probably many of you may or may not know. I trained at the Medical College of Wisconsin in Milwaukee, which Dr. Bailet is familiar with.

Dr. BAILET. Yes. Yes, I am.

Mr. BUCSHON. I'm going to make a couple of things—first of all, just to remind everyone, you know, provider reimbursement is about 8 to 10 percent of the overall healthcare dollar.

Obviously, MACRA was really—is extremely important but getting it right is even more important. But I think it's important for the American public to know that we still continue to have cost challenges in our healthcare system and addressing things at the provider level is only one part of the equation.

That's where, you know, I hope we're not talking about a zero sum game when it comes to specialists and primary care because primary care clearly has been under valued in our system.

That said, also as a specialist I can say that, you know, specialists are also very important. And so if we end up doing this very—this poorly where we address this as a zero sum game, resulting in provider reimbursement cuts for quality care depending on what type of medicine that you practice, the only thing that's really going to result is access issues for the America's seniors because of the—what I said earlier. It's only 8 to 10 percent of the overall healthcare dollar. That's why these hearings are extremely important.

So since I trained at the Medical College of Wisconsin I'm going to ask Dr. Bailet——

Dr. BAILET. I knew it was coming—a question.

Mr. BUCSHON. No, I know you're not testifying on behalf of this, but you were selected to chair the Physician Technical Advisory Committee, PTAC.

Dr. BAILET. Yes.

Mr. BUCSHON. Can you just kind of go over and explain briefly to the committee what you perceive as the role of PTAC—-

Dr. BAILET. Sure.

Mr. BUCSHON [continuing]. Why you wanted to be part of it, and what role you think it's going to play in development of physician-led APMs.

Dr. BAILET. So PTAC was set up to be an independent advisory committee that advises the secretary of HHS on alternative payment models specifically related to physician-focused payment models.

The committee started in January. We had our first public meeting in February. We have our second public meeting in May.

As the chair, my goal is to because, again, the rules have not been released so the activities of the committee we are functioning and spending a lot of time familiarizing ourselves with each other because this committee needs to work at a high level.

We're also right now creating bylaws and rules of engagement so that when the rules are out we will be prepared to start looking at model proposals straightaway.

One of the areas that we're working on and we're looking at stakeholder input right now is what is the scoring system the committee is going to use to look at models—what are we going to look at as it relates to important elements—what weight will those individual elements get.

We want to be able to have a transparent process that the stakeholders have input into developing with us but more importantly that they understand when they're submitting models that the process for submission is streamlined, they know what needs to be in their models. We're going to provide assistance as best we can for select submitters and, again, we're advising.

If you ask me 2 years from now what would I consider a success for the PTAC committee it would be that the committee has the level of credibility with the stakeholders but also the secretary and our recommendations have a high level of influence and we are willing and able to put together recommendations for models that in fact CMS will see the merits and undertake them.

Mr. BUCSHON. That's great, and I had a conversation with CMS earlier this week about the RUC recommendations on provider reimbursement and I also spoke to them about PTAC and my hope would be as exactly as you say is that the recommendations that you're going to be creating in a very thoughtful and fact-based process, through a thoughtful and fact-based process we'll be taking into serious consideration in contrast to sometimes RUC recommendations on provider reimbursement which seem to mostly be ignored.

So developing these APMs can be a—I don't want to necessarily focus on you but this—but I have this question for you. It can be very difficult for small specialties in diverse skills and medicines.

Can you maybe—and anyone can discuss this—can you discuss the challenges with that and how PTAC might be able to engage in that discussion to help smaller practices and, you know, we talk about rural communities and others developing and participating in APMs.

Dr. BAILET. Well, I'll be brief and let my colleagues also answer. The PTAC needs to be reflective of the fabric of the United States and the care systems that are delivered from rural communities.

We have communities in Wisconsin of towns of a thousand that we have to provide care for. So we need to as we look at models make sure that it's inclusive of the population that we're trying to treat.

So yes, there will be large metropolitan communities and specialties that can put forth models but we also have to make sure that the elements of the model as we weight them reflect and respect the smaller communities and allow them to participate and——

Mr. BUCSHON. My time has expired so——

Dr. BAILET. Oh, I'm sorry.

Mr. BUCSHON [continuing]. And I appreciate that input, and I would just reiterate that we do have to make sure that all of our communities are included. Thank you.

Mr. PITTS. Chair thanks the gentleman and recognize Mr. Cárdenas, 5 minutes for questions.

Mr. CÁRDENAS. So thank you very much for enlightening us with your information, and hopefully we'll learn more about what's going on in the streets and corridors of your side of the world.

But in a nutshell, if you could please expand on at least one example of how we could make sure that what is going on is being implemented for the benefit of our constituents, maybe some things that need to be clarified or at least one example of what we can help you do better.

Dr. WERGIN. I could start off. The one area that I think it's interoperability of electronic health record, and again, being a rural family physician that treats children to adults who sometimes or in other urban ERs I get 18-page fax notes from an ER that I have to go in and ask the patient why did you go to the ER and what did they do—I can see your mother was of Mediterranean descent but I don't think that's why you went to the ER. There's lots of information there. It's faxed into my record, making it nonsearchable.

So I think one thing we could do is set a platform to push the vendors to say you have to have some level of interoperability that it will help me take care of your mother or your child when I have to coordinate that care, and that's important.

And one other point I'd make, if you look at Medicare expenditures 1 percent costs 23 percent, 5 percent costs 50 percent, I think the rule of thumb there is don't let them get in the 5 percent or 1 percent. That's my job.

Dr. MCANENY. I would add to that that one of the concerns that we have is what is nominal risk and defining nominal risk in such a way that I as a small practice managing physician can cope with it.

For me, since I am not an insurance company, I do not have reserves. There's other types of risk besides financial risk. If I hire a new employee I'm guaranteeing a salary and benefits.

To me, that's financial risk. If I'm leaving gaps in my schedule for same day patients to me that's financial risk. So one thing that Congress in particular and this committee definitely can help with is to let CMS work with us for that understanding of risk and also let practices as they develop their measures give us a chance to try that.

Help us along with what we need to learn from the PTAC and from the AMA and from other organizations so that we can try things. Some of it won't work but don't put us out of business if it doesn't work because then we can't serve the patients in that community.

Mr. CÁRDENAS. So we're not—just so the people watching on SPAN are clear, you're not talking about trying things that puts the patient at risk—you're just talking about administrative aspects of how to be more efficient and do a better job?

Dr. MCANENY. I apologize for that. You're absolutely correct. New structures of care—if we try a specific team approach if it doesn't save money but it delivers better care we don't want that one thrown out, the baby with the bath water.

Dr. BAILET. Yes, I would agree. I think the flexibility is absolutely key that things like the definition of what's nominal risk that may come out in the proposed rules but I think that's a big uncertainty—what does that mean—and I think the goal is to

broaden the appeal of this to different size, different geographic area so that everyone can be trying to do this right.

But it's going to take some trial and error in some ways in terms of how physician practices do it. Clearly, we don't want any sort of risk to be at the level of the patient.

mean, there are other things where I think things need to be done well and carefully and thus far CMS has done, I think, a good job of getting our organization's input on how to do it right but things like patient attribution, risk adjustment—those are really complicated concepts and I think it would really frighten physicians if they thought that bureaucrats in Washington were making those determinations and not the physicians who actually understand that a bit better.

So I think really kind of making sure that CMS is going through that process the right way with the appropriate input, which they've done so far, is probably one of the most important things that you guys can do.

Mr. CÁRDENAS. In the interest of time, I would love to hear more dialogue but my time is winding down. But how many of you have had the opportunity to personally get to know how health care is delivered in another country? So if you have, please say yes. If you haven't—it's not a criticism. I'm just curious because a lot of Americans think that we're embarking on models and practices that nobody in the world has ever done and I don't think that's true.

Heaven forbid we would admire another country for what they do. We wouldn't do that as Americans but have any of you actually been to another country in the healthcare space and got to see what they do? Yes or no.

Dr. BAILET. Yes. Yes.

Mr. CÁRDENAS. Yes? One? So two yes, two no. Well, in the interest of time, a million more questions but not enough time. But thank you so much, Doctor, Doctor, Doctor, Doctor. Thank you.

Mr. PITTS. Chair thanks the gentleman and now recognizes the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Ms. ELLMERS. Thank you, Mr. Chairman, and thank you to our panel. I'm going to follow up on the gentleman's line of questioning because I was going to ask about nominal risk and how we should be best defining and in your opinion—and this is going to go to the entire panel—on some more of this discussion because I think this is very, very important, especially for individual physician practices.

You know, we sometimes take the hospital setting which, obviously, has a little bit more ability to incorporate and utilize those resources for a better product where our physician practices, you know, really have minimal resources to dedicate.

So, one, you know, and it goes into the discussion of interoperability. That has to be part of what is considered in that risk as well, I believe.

So I look at risk as how are we able to better empower our physician offices to be able to—to have that ability to share information, one, the infrastructure itself, the HIT—the health records themselves and establishing the personnel.

And this is kind of that conversation that we've been having now for a couple of years and the promises that were made initially that, you know, we were just going to go through this learning curve and everyone was going to be in a better place obviously has not taken place yet and it's very difficult for our physician offices, especially with all of the other rules, regulations, changes in health care that have taken place.

So I guess I just want to hear a little bit more conversation from all of you on what we do need to be doing here in Congress to help all those things, especially when it comes to the interoperability.

How can we help physician offices to be able to have that knowledge on that patient when they come to the office after being seen in the emergency room? How can we make sure that that information is being shared and how can we better help our physicians to incorporate that as the risk that they're assessing?

Dr. MCLEAN. So I think that the interoperability is, obviously, a big issue and I think has been one of the frustrations that even as physicians have gotten into electronic health records they can't access data elsewhere, and what I'd mentioned earlier—big data.

You know, part of big data is big data at the small practice level and what do I need to access and my patient, who was at an ER at another part of the State. But then there's also the big data of if in fact my practice small or large is looking at my population of patients and my population health, which is kind of whole other concept when you're looking at trying to deliver good care, making sure that, you know, all of my diabetics have X, Y and Z done because there are people that fall between the cracks.

And until you're able to look at big data and have the analytics to do it you don't even know that. Everyone thinks they're doing a great job until they actually look at the data and they realize that there are things that they're missing despite their good intentions.

So interoperability is key to that and I think that while there are different State initiatives that have tried to break down some of those barriers I think at least in Connecticut it has not worked well.

There was kind or a commission that was trying to do it. It just didn't happen. I think other States have done it very successfully. I think Rhode Island in particular, if I can think of one.

But I think a Federal guide to making interoperability happen because people need care across State lines. So even if you have rules in one State, it's not going to necessarily, you know, work.

So it's really incredibly important to allow for accessibility of data for direct patient care but also for the big picture of big data analytics and data management when you're looking at trying to take care of your population of people.

Ms. ELLMERS. All right. Thank you.

Dr. WERGIN. I had a comment about the virtual risk and, especially, again, being in a small practice, which, you know, there are actuarial pools of patients, but if you're in a small, limited area or geographic, you can do it with virtual groups to get larger numbers of patients.

But how do you define what the nominal risk is for that pool, and that comes down also to the attribution process. We'd hope it would be prospectus—that we know what patients were.

In primary care we're responsible for and set up treatment plans and ahead of time rather than how it usually is. You get a list of patients and say who are these 10 people—I don't even know who they are.

So we need to know that, but a way to make these smaller practices pull together if that's how they're going to define nominal risk.

Dr. MCANENY. A couple ideas that I would love to throw out. One is that a lot of States have tried to create health information exchanges yet some of the big institutions put walls around their data so that they can keep the patients to themselves and not let them go elsewhere.

Those walls need to come down so that we can take care of patients wherever the patients want to be taken care of.

The law of small numbers concerns me a lot in the attribution. If my primary care colleagues happen to have 10 patients with cancer that year instead of the 5 that they thought they would and my expensive drugs become attributed to them, they will have a problem in trying to be compared fairly.

So we're very concerned about being able to have good attribution and that's still a science in its infancy. And the other thing that will help a lot is if we can get Medicare claims data back to us in a timely fashion because if I can see a problem and I can figure out a way to fix it, that gives me a lot more ability to take care of patients than if I learn about something 2 years later when I don't even remember or have any idea what I did right or wrong.

Ms. ELLMERS. Right. Absolutely. And I do want to add to your comment about, for instance, patients with cancer and, you know, the smaller practice because I know that, you know, CMS is proposing some more changes to Medicare Part B drug reimbursement and that is going to play in—and just there again if you don't mind commenting.

I didn't really want to go into that aspect of this because it kind of gets into the weeds. But how do you think that plays into this conversation that we're having today? Do you agree that it'll become more difficult I guess is what I'm asking.

Dr. MCANENY. Well, we didn't come here to talk about the ASP changes so I'd be happy to talk with you offline about that issue. But yes, it's very important to us.

Ms. ELLMERS. And we will follow up with you on that. Thank you.

Dr. MCANENY. I will.

Ms. ELLMERS. Dr. Bailet.

Dr. BAILET. So I concur the interoperability is a problem. I think that feedback so the CMS is going to be tasked with providing real time feedback on profiles of their effectiveness particularly in the MIPS and alternative payment models.

So I, again, fundamentally believe, having led physicians for a number of years they want to do the right thing and they will respond to data that is meaningful and when they look at it it says, you know, this reflects my practice.

So that feedback is going to be important. So getting access to the claims data but in a way where, again, it's real time and it can make a difference. If it's too far out of line of sight the impact is going to be limited. So I think in the interests of time I would stop there.

Ms. ELLMERS. Well, I just thank you so much and we went way over and I ask apology from the chairman. But thank you and thank you to the panel.

Mr. PITTS. Chair thanks the gentlelady and now recognize the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman, and I am not a doctor but I did play one on the—play one on the radio for several years and I remember my first trip to my doctor on one of my semiannual visits after the passage of some call it Obamacare, others call it Greencare.

But we—from somebody from Texas it's hard not to get the word out. But on that visit to the doctor right after Obamacare had passed I thought I was going to have to prescribe him a blood pressure medication because he said—at the end of my visit he said, you sit right there—he said, you're going to sit there and I'm going to turn around and I've got to enter all this into the computer.

He said it used to be—remember what used to happen? He said, I'd send you out and you'd get your next visit and you'd be out of here, but you sit right there while I enter this.

He was several years from retirement age, and he retired about six months after that. Such as my district director's doctor also retired. I could go down the laundry list of people that have retired—doctors that have retired.

And I do have something in common with the author of this, Mr. Green. Both of us have daughters that are doctors, and my daughter is a pediatrician who's in her first year—wrapping up her first year of residency.

So I'm sure the young doctors out there as my daughter is coming on want to know what's going to be out there in the future.

So with that being said, Dr. Wergin, you bring several unique perspectives to the panel. Can you describe some of the specific challenges of practicing in rural areas?

I have a lot of rural areas in my congressional district and the pressures providers in similar situations face to remain in practice like my doctor.

Dr. WERGIN. Yes, I think the rural providers that I represent and I represent personally—I am one—that you have limited resource. Mental health services, for one, are tough. That's where telehealth might be able to help us. But we need infrastructure to do that.

I mean, they don't do it. But really finding the resources in your communities and identifying them and you have to be in—meaning using church groups. I use church groups for people that run out of food and it's kind of nice because I don't have to give them 5 years of tax forms and all that. I just call the minister and say, this lady is out of food. So identifying resources in my rural areas and the challenges there.

The other thing is burnout. Your patients love you and they almost love you to death. In primary care, our care is delivered.

We're a continuous time in a relationship, tremendous confidence in my care.

Sometimes I even have trouble getting patients to go to other providers and like Dr. Bucshon—they say, well, can't you put my new aortic valve in, Dr. Wergin, and I have to say no, I got to draw the line somewhere on comprehensive.

So I think that relationship-based care, and then I think the other thing we see is how do you recruit people—the millennials into rural-based care and in rural States I'm sure you face that is how do you—debt relief, there's carrots out there you can give them but who's going to take my place, et cetera.

But the resource utilization you have, especially care, is usually miles away but they're great in creating that and systems like in Wisconsin are a way to do it.

But it's a rewarding career but we have to sell that to the medical students and mainly their wives because they're going to move to a rural area.

Dr. BAILET. Or husbands.

Mr. LONG. Dr. Bailet, in your testimony you discussed challenges faced by small, solo and rural practices also. Can you speak to your efforts to provide these critical access points of care with tools they can utilize to succeed, particularly through your clinically integrated network?

Dr. BAILET. Yes. In these smaller communities we philosophically believe the care is local and should be delivered locally as best it can. But there are times when patients have to leave these smaller communities to get specialty care.

So we spend a lot of time making sure that the physicians in these smaller towns and clinicians, because it's not just physicians, have the resources—the support of a larger system.

We try to create virtual outreach. So we have TelePsych, for example, that we're offering these physicians. Again, for them to want to go into smaller communities they don't want to be an island.

They want to be connected to the physician community at large because, again, they want to have these assets for their patients.

So the more we have these interconnected points with our patients whether it's TelePsych or we have TeleStroke, we can bring those attributes out to the community so these physicians in smaller communities feel like they have a team behind them to be able to manage the patients.

And yes, there are times when you have to convince the patients to leave the community for their care. But we work very hard to return those patients as soon as possible, again, with that electronic record, with that team support so that the physicians who are treating these patients feel like they have a safety net to be able to manage them if there's a complication or additional questions that come—that come up.

Mr. LONG. OK. I think I'm out of time so if I had any I'd yield it back.

Mr. PITTS. Chair thanks the gentleman. That concludes the question from members present. We're going to go to one follow-up per side. Chair recognizes Dr. Burgess, 5 minutes for a follow-up question.

Mr. BURGESS. Thank you, Mr. Chairman. This really has been a wonderful panel. I do feel obligated to mention since interoperability has come up so much this morning that yes, part of the effort in passing the H.R. 2 was to deal with that but then a larger effort is—has been included in H.R. 6, which was the Cures for the 21st Century and that bill, of course, passed the House last summer and is pending before the Senate. So please don't think we've taken our eye off the ball on interoperability. It remains an important marker to achieve.

Dr. McLean, let me just ask you, and you all have been very thorough in your testimony today. But I'm always struck in dealing with the stupid SGR that it was the update adjustment factor that really did violence to doctors.

Now, that's the conversion factor. You talk about every doctor gets their own—can create their own conversion factor. And at the risk of being too wonky, can you kind of go through that at a high level so our friends in the press can get that?

Dr. MCLEAN. No, no. I thank you very much. I'm very happy to answer that question. So I'm not certain how wonkish some of the committee is.

But when the Medicare physician fee schedule is calculated on a fee basis—you know, it's fee for service—there is every item, procedure, office visit, E&M code—evaluation management code, as we call it—has an RVU—relative value unit—kind of number and this is what the RUC works on, kind of changing and calculating year to year.

And that number, that RVU, is multiplied times a conversion factor every year to end up giving you kind of the dollars per visit for a—whatever.

And that conversion factor was changed—I mean, so with the SGR, depending upon what the SGR kind of kicked out as what the adjustment should be, that conversion factor for every service—physician service was cut by a certain percentage to begin with and then because the can got kicked down the hill it kept going—growing and growing. So it was, whatever, 28 percent in the—at the end.

And so now it's effectively—the conversion factor will be individualized based upon, for example, their MIPS score. So it's tremendously empowering to physicians to kind of think that if I'm actually doing a better job in some of these various quality measures and things, I will be judged myself for how I did.

And I think when we talked about burnout a little bit I think one of the—one of the factors of burnout in addition to regulation and trying to deal with EMR and other changes is that financial anxiety and the fact that now at least they have control over that anxiety I think is huge.

Mr. BURGESS. What is the—you know, we talk about things being iatrogenic in health care. What would be the congressional equivalent of that? Because the anxiety—much of the anxiety that many of you have spoken about this morning was actually generated by Congress or the agency.

It wasn't directed—it wasn't generated by physicians or the practice of medicine. There's enough anxieties in the practice of medicine but we generated anxieties here.

Dr. Bailet, let me just ask you a question on that. We kind of covered some of the stuff with the physicians technical advisory committee.

But can you give us perhaps a bit of a sense of how this compares and contrasts with the Center for Medicare and Medicaid Innovation that was also—is also one of the things that's been visited upon physicians?

Dr. BAILET. The CMMI?

Mr. BURGESS. Yes.

Dr. BAILET. Yes. So I think that the work that was done under CMMI was sort of planted the seeds of innovation and those kinds of models and our care designs that came out of that I believe they're going to be contributing to the innovation that's injected into the models that the PTAC will consider. I'm hoping I'm answering your question.

Mr. BURGESS. Well, I guess the one philosophical difference that I see, CMMI is driven by the agency and it may or may not make sense to the practicing physicians.

PTAC is driven by docs.

Dr. BAILET. Yes.

Mr. BURGESS. And my hope is that that will make sense to the practicing physician. Is that a fair assessment?

Dr. BAILET. Yes. It has to.

Mr. BURGESS. OK.

Dr. BAILET. And I think that I've heard and I can say—speak for the committee to the individual level that is absolutely paramount and that is—that is the desire of this committee.

Again, we respectfully understand that it is an independent body and an advisory body but absolutely, and we are—we are doubling down on our efforts to listen to the stakeholders and, frankly, our output is to some degree—to a large degree going to be as good as the input of the stakeholders as they come forward.

Mr. BURGESS. Much of this—as the bill itself was into the development stages, stakeholders, especially groups' physicians, would come to us and say we've been doing this for a while and we think this is a good idea.

But we've got no way for CMS to—no way to bring it to CMS and have them evaluate it and incorporate it. And now PTAC actually provides that avenue and, importantly, if it's not accepted people have to be told why it wasn't accepted and my hope is that will give them another opportunity to impact it.

Dr. BAILET. Resubmit. Right. Again, that is our plan, to come up with a blueprint for people to be able to follow and to provide advice and guidance to allow resubmission if there are challenges or potential weaknesses with their proposals.

And, again, we want to be as comprehensive and transparency is key here to make sure that once we get the feedback from the specialty communities and the other societies that we develop a model that is transparent and anybody wherever they are, wherever they are in their readiness and abilities can look at this and say look, I want to participate—I want to create a model and they have—they have the blueprint that then they can apply their potential proposal in order for the PTAC to critically evaluate it, and

right now we are right in the middle of that—developing that process of analysis.

Mr. BURGESS. Great. That's the right answer. It gives me great peace.

Mr. Chairman, I would just say after well over 10 years on this subcommittee one of my fondest wishes was to come in here someday and have a panel of doctors tell us how much economists should be paid. So if you all want to respond to that in writing I'll be happy to listen.

Mr. PITTS. All right. The Chair thanks the gentleman and now recognize Mr. Green, 5 minutes for questions follow-up.

Mr. GREEN. Thank you, Mr. Chairman.

Dr. Bailet, you brought up the potential impact of MACRA to transform patient care. Can you describe how you can see the APMs are beneficial to the—to the patients?

Dr. BAILET. Well, I mean, these models are—the underpinnings of these models are to impact patient care to provide high-quality care, enhanced patient care, obviously, with smarter spending.

But the elements in the models will be—the underpinnings will be moving the quality spectrum forward to make sure that that outcomes, and that really is the point of the round here is the actual outcome.

You know, there are—there are metrics A1C—there are targets that we—that we strive for as a practice. But I also think what these APMs will be able to do across populations is actually look at outcomes, not just the fact that the diabetic patient has an A1C less than seven but what are some of the other parameters of their functionality, some of the other morbidity and mortality associated with the disease—what are we actually changing their health status and being impactful and I believe the APMs will allow us to do that.

Mr. GREEN. Any of the other panel?

Dr. MCANENY. Yes. I would like to add on that on a very personal experience because in participating in my oncology medical home process we've had—in order to have that money from the innovation center come to us to be able to allow the practices to spend money on nurse educators who could teach patients what's going on, nurses doing triage on the phone.

We brought patients in, 15 to 20 same-day visits every day. We cut the rate of hospitalization for cancer patients by over half.

Patients were thrilled to be able to see us on the weekends and on the same day that they needed to see us. And so it was a very immediate way that we were providing patients because of this APM with the care that they needed when they needed it and where they could get it at a lower cost.

Mr. GREEN. Dr. Wergin.

Dr. WERGIN. I just had a brief comment. Moving away from a face to face volume-based system to an APM will give you the resources that is focused on the patient and the patient-centered home it starts with the name patient, and that's what it means.

You focus on the patient, the care they need, when they need it and that's been addressed. So I think APMs can move not to just save money because I'm interested in that—more importantly, I want to improve the health of the community I live in.

Dr. MCLEAN. I was just going to add I think that moving—the APMs incentivize physicians and physician groups to get into kind of systems or affiliations that allow them to, as I mentioned before, to deal with big data, and that big data is not just seeing how many people, you know, got their A1C done in six months.

But it's looking at well, the people who didn't what's different about them—what happened—why is this group of people not getting, you know, diabetic foot exams.

It allows people to kind of intervene and make a difference in health care, and when you're in small kind of groups sometimes you don't have that big data to do and as I say people fall between the cracks and you don't even realize where the system is failing a lot of our patients.

There's less duplication, which saves money. Interoperability helps with that. I mean, it just—it aligns very many things into one kind of direction and that's really one of the major things we've been lacking.

Mr. GREEN. OK. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. Chair thanks the gentleman. That concludes the follow-up questions. We will have other follow-up questions in writing that we'll send to you and other members who aren't here will have some questions.

We'll ask you please to respond promptly. I remind members they have ten business days to submit questions for the record and that means they should submit their questions by the close of business on Tuesday, May the 3rd.

Excellent hearing, very thorough testimony. Really exciting and optimistic hearing today. We'll monitor closely this implementation. This is the second hearing. We will have more.

We look forward to working with you. Thank you very much for coming and presenting your testimony and sharing your expertise with us.

Without objection, the subcommittee stands adjourned.

[Whereupon, at 12:08 p.m., the hearing was adjourned.]

[Material submitted for inclusion in the record follows:]

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Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

American College of Cardiology
April 19, 2016
Statement submitted for the record to the House Energy and Commerce Health Subcommittee
United States House of Representatives

The American College of Cardiology (ACC) is pleased to submit this statement for the record to the House Energy and Commerce Health Subcommittee for the April 19, 2016 hearing, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

The ACC is a 52,000-member medical society that is the professional home for the entire cardiovascular care team. The mission of the College is to transform cardiovascular care and to improve heart health. The ACC leads in the formation of health policy, standards, and guidelines. The College operates national registries to measure and improve care, provides professional medical education, disseminates cardiovascular research and bestows credentials upon cardiovascular specialists who meet stringent qualifications. The ACC also produces the *Journal of the American College of Cardiology* (JACC), ranked number one among cardiovascular journals worldwide for its scientific impact.

The College is pleased to see Congressional oversight of the *Medicare Access and CHIP Reauthorization Act*, or MACRA, continue as the House Energy and Commerce Health Subcommittee holds a second hearing on this topic, this time specifically focusing on the clinician perspective. Since MACRA was signed into law, the ACC has been focused on educating cardiologists, cardiovascular care team members, and cardiology practice administrators on the transition from the current value-based payment programs to those coming under MACRA. The ACC has formed a member-driven MACRA strategic taskforce that meets monthly to develop recommendations for the College's role in aiding its members in successfully meeting the requirements under the new payment system. The taskforce is also focused on coordinating efforts of the College through advocacy, quality measure development, and the continued development of our clinical data registries to meet these needs. In addition, the ACC has published articles in the *Journal of the American College of Cardiology* related to MACRA, held several webinars, and has hosted seminars with representatives from the Centers for Medicare and Medicaid Services (CMS) at its annual meeting to educate cardiovascular clinicians on the impending payment system and supply further information on how to be successful in the new payment system. The ACC remains engaged in conversations with CMS and other stakeholders and these conversations remain positive and productive.

In response to the October 1, 2015 CMS request for information, ACC urged CMS to ensure that the MIPS and APM pathways be based first and foremost on supporting the clinician's ability to provide high-quality, evidence-based care to Medicare beneficiaries. In addition, the College stressed that the new payment system under MACRA must apply appropriate measures and requirements that recognize the diversity of clinicians and patient populations, and that CMS must continue to work with medical specialty societies and practices to ensure that program requirements fit within the clinician workflow and are not administratively burdensome.

Other ACC recommendations included in its response to the CMS request for information:

- Since Meaningful Use is a component of the MIPS score, CMS should reopen MU Stage 3 to realign the program to focus on interoperability and usability, and evaluate whether clinicians are successful under the Stage 2 Modifications rule. CMS must also eliminate the pass/fail approach to the program before integrating it into the MIPS program.

- Quality measure reporting requirements should be based on clinicians reporting the most clinically meaningful measures based on their specialty and services provided. Arbitrary thresholds such as reporting a certain number of measures according to the National Quality Strategy should be eliminated.
- The collection of valid performance data is essential to a pay-for-performance system. CMS should collaborate with Qualified Clinical Data Registry vendors such as the ACC and practices so all stakeholders can better understand any data issues and work together to resolve them if they arise.
- All resource use measures should be appropriately risk-adjusted so clinicians are not penalized for treating chronically ill patients. In addition, each resource use measure must be counter-balanced with an appropriate quality measure.
- CMS should not mandate participation in any specific activity under the new Clinical Practice Improvement component of the MIPS program. Clinicians should be permitted to participate in those activities that meaningfully drive improvements in care based on their patient population, specialty and practice size.
- CMS must provide clinicians with usable, accessible and actionable feedback reports that truly allow them to assess their performance and identify areas for improvement. Current feedback reports provided by CMS, such as the Quality Resource and Use Report (QRUR), are highly technical and difficult for many clinicians to understand.
- CMS and the Centers for Medicare and Medicaid Innovation should continue to work with the private payer and clinician communities to align quality measures and reporting requirements, allowing clinicians to easily transition between the MIPS program and APM participation.

MACRA is a bipartisan product of a multi-year Congressional effort that was constructed in close consultation with specialty associations. MACRA creates a new payment system that pays clinicians based on quality and value rather than volume. MACRA recognizes that quality and value are not one-size-fits all concepts across specialties. Flexibility will be required to ensure that the system truly rewards clinicians for their efforts to provide evidence-based care and seek innovative ways to manage costs without threatening patient outcomes. Because of these fundamental positives, the law is necessarily complex. Working to streamline the new payment system and make it understandable to clinicians is a priority of the College. We commend CMS and the Administration for continuing to seek the perspectives of clinicians across specialties as they navigate the implementation of this complex law and encourage Congress to do the same in its oversight.

As the roles of each clinician in the process are being defined under MACRA, the unique role specialty providers, such as cardiologists and all members of the cardiovascular care team, play in the process must be recognized. Cardiologists typically care for patients who have multiple complex conditions and require coordination between multiple clinicians. New payment models should be reflective of this population and the clinicians who care for them.

Again, we applaud the Subcommittee for holding this hearing and look forward to additional Congressional oversight of MACRA following the release of the pending MACRA proposed rule and beyond.

Statement of the
American College of Surgeons

To the Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

RE: Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

April 19, 2016

On behalf of the more than 80,000 members of the American College of Surgeons (ACS), I would like to thank the Members of the Health Subcommittee for holding this important hearing on the work being done by physicians to prepare for new payment models and requirements in MACRA. We appreciate this opportunity to provide you with a summary of some of the efforts ACS has undertaken that we hope will improve the accuracy and efficiency of the Medicare payment system and ultimately improve care for surgical patients.

Since the passage of the *Medicare Access and CHIP Reauthorization Act* (MACRA) in April 2015, there has been a tremendous amount of activity in the area of physician payment. While it is common to read about the 5 year "period of stability" that commenced with the bill's passage and which extends through 2019 when the Merit-based Incentive Payment System (MIPS) goes into effect, in reality physicians must be ready to meet the new program's requirements as early as 2017.

In addition to repealing the Sustainable Growth Rate (SGR) formula that resulted in the need for annual legislative "fixes" to prevent cuts to providers, MACRA creates two paths for participation in the Medicare program. Those who wish to continue to primarily bill as fee for service providers can continue to do so. However, these fee-for-service payments will be increasingly impacted by the four components of the MIPS program, namely quality, resource use, meaningful use of the electronic health record, and clinical practice improvement activities. Providers may also have the option of participating in an Alternative Payment Model (APM) that provides greater flexibility in care delivery but which includes greater risk of financial losses if care costs exceed what is expected. Both routes have advantages and risks, but over time there will be growing financial pressure for physicians to move to APMs.

Fortunately, MACRA provides ample opportunities for input from physician societies and other stakeholders throughout the implementation process. In fact, in some areas, like development of APMs and quality measures, the physician specialty societies are responsible for ensuring the law works for their members. ACS has made MACRA implementation a top priority and is working diligently to shape the new MIPS payment structure and develop APMs that meet the requirements of the law in order to provide options for surgeons. Below are several specific areas of particular importance to surgeons.

MIPS Implementation

Developing New Quality Measures

One of the most important aspects of MACRA is the opportunity to streamline and improve existing CMS quality programs. The current measurement approach is narrow, complex, costly and sluggish. The measures available to surgeons in the Physician Quality Reporting System (PQRS) are often irrelevant to surgical care because a single set of measures is very difficult to translate to an individual general surgeon due to the diversity of procedures general surgeons perform. Procedures vary from surgeon to surgeon based on their patient

population, subspecialty, and geographical location. As a result, the current approach has likely slowed down the engagement of providers thereby hindering the ability to drive improvement.

In order to address the measurement of surgical care in the MACRA environment, ACS has developed a comprehensive approach to surgical measurement which follows the various phases of surgical care. ACS has a rich history in quality improvement. For more than 100 years, ACS has led national and international initiatives to improve quality in hospitals as well as the more specific fields of surgical quality, trauma, and cancer. All ACS quality initiatives are built on the following key principles: setting clinical standards, building the right infrastructure, using the right data, and verifying with outside experts. These principles led the development of the comprehensive framework spanning across the phases of care, including preoperative, perioperative, intraoperative, postoperative, and post discharge. This framework is comprehensive because all surgical patients experience these phases of surgical care during the course of their treatment. These phases involve key processes, shared decision making, critical care coordination with primary care physicians, anesthesia and other specialists as well as the technical components of surgical care relating to safety, outcomes and prevention of avoidable harms.

These metrics are different from measures in the current PQRS because they broadly apply to almost all surgeons, span across the various phases of surgical care, and when measured together they can have a real impact at the point of care. ACS has defined the below set of metrics for cross-cutting comparisons and they have been constructed to allow for more detailed, procedure-specific metrics to be added when necessary. The ACS strongly believes that when taken together, these measures represent an effective way to improve quality, and coordinate care and lower cost while increasing both patient and provider engagement.

Phases of surgical care measures:

1. Surgical Plan and Goals of Care
2. Identification of Major Co-Morbid Medical Conditions
3. Preventative Care and Screening: Tobacco Screening and Cessation Intervention
4. Preoperative Key Medications Review for Anticoagulation Medication
5. Patient-Centered Surgical Risk Assessment and Communication
6. Patient Frailty or Functional Index
7. Perioperative Composite
8. Postoperative Care Coordination and Follow-up
9. Unplanned Hospital Readmission within 30 Days of Principal Procedure
10. Participation in a National Risk-adjusted Outcomes Surgical Registry

Meaningful Use

Both MIPS and APMs will continue to require the use of certified electronic health record (EHR) technology in providing patient care. In a blog post earlier this year, Acting CMS Administrator Andy Slavitt indicated that major changes to the EHR Incentive Program, or Meaningful Use (MU), include "transitioning from measuring clicks to focusing on care." ACS agrees that passage of MACRA should be seen as an opportunity to step away from the

current provider burden experienced with MU which detracts from patient care. MACRA provides an opportunity to improve interoperability by leveraging a data ecosystem (EHRs, registries, and multiple other data sources) to enable clinical decision support at the point of care and for meaningful discussions, including shared decision making. Common data standards are absolutely critical to achieve this vision of interoperability.

The College is dedicated to the use of clinical data with common data standards to improve outcomes and the quality of patient care—EHRs, clinical data registries and other data sources are all critical pieces which form the clinical data ecosystem. ACS has taken many steps to demonstrate our commitment. We have been a national leader in innovative quality improvement by building our initiatives on the key principles mentioned above. Guided by these principals, we have recently embarked on a project to develop the "registry of the future" by building a comprehensive and integrated clinical registry platform that combines data from more than 1,800 hospitals across the United States, international medical contributors, and individual surgeons to improve surgical outcomes for millions of patients.

Additionally, last year ACS convened stakeholders from various branches of the government, the physician community, academia, think tanks and the private sector in our first Clinical Data Ecosystem Summit with the goal of freeing the data in EHRs, through the use of standardized data points for use in an open architecture system. Last week ACS took The Office of the National Coordinator for Health Information Technology's (ONC) Pledge to Improve Interoperability.

Alternative Payment Model Development

Perhaps the most impactful portions of MACRA on the future of physician payment are the provisions on developing APMs and the multiple incentives aimed at introducing more physicians to these payment structures. MACRA encourages physician led development of new models and created a new Physician-Focused Payment Model Technical Advisory Committee (PTAC) tasked with providing feedback on APMs developed and submitted by Stakeholders. Incentives to participate in new models include credit in the CPIA portion of MIPS, exemption from certain MIPS reporting requirements, a temporary 5 percent incentive payment to reward successful early APM participants, and partially offset the costs of transitioning to new models and higher payment updates for successful APM participants starting in 2026.

ACS received the message on the importance of APMs in MACRA and is investing significant resources in developing APMs to allow surgeons the opportunity of transitioning to new models that qualify them for these benefits while improving care. Our partners in the process include Brandeis and the Center for Surgery and Public Health at the Brigham and Women's Hospital, & their Harvard faculty. The ACS APM project is ambitious and is designed to be inclusive and scalable, coalescing as many of the surgical disciplines as possible into a single framework of options and providing solutions suitable in an all-payer model. It is our intention to present a proposal to CMS and CMMI for approval and implementation as a demonstration by the end of 2016. While many of the details of our proposal are still developing and rules have yet to be issued by CMS as to what the

requirements of a qualified APM will be, we have moved forward with the project to meet MACRAs demanding timeline.

More than a dozen surgical disciplines and other specialties directly involved in surgical care are currently participating at various levels of engagement. The idea started as bundles built around defined episodes of care triggered by a diagnosis or procedure which could then be built into APMs (not dissimilar from those in the Bundled Payments for Care Improvement Initiative or BPCI) but has evolved rapidly. We are now exploring multiple options including APMs built around episodes, chapters of care including multiple episodes or Clinical Affinity Groups or CAGs which incorporate multiple chapters of care. This structure has the potential to grow beyond surgery and include other specialties and primary care into integrated care models.

To better fit the needs of the patient, we began our process by defining the clinical construct of an APM based on the providers a patient with a given diagnosis is most likely to see and the services they are most likely to require in the course of their treatment, around an episode of care. We soon realized that building APMs using the Brandeis method and episode grouper software could open the door to combining multiple episodes into chapters of care, thereby coordinating multiple clinical disciplines and other parts of the delivery system working together in the course of a patient's treatment. Examples include cancer care, trauma care, cardiac care, musculoskeletal care, or common chronic condition chapters.

By further expanding the model to incorporate multiple treatment options (chapters or episodes) for a given condition or patient population as well as prevention efforts, a Clinical Affinity Group (CAG) can be created. Each CAG comprises a number of clinical chapters or smaller service lines. For example the cancer CAG may consist of three separate sub-service lines; 1) Prevention and detection, 2) Surgical treatment, and 3) Chemotherapy and radiation therapy care. Each of these chapters in turn could contain one or more episodes of care. The APM could be designed and built at any level by adding or removing component parts such as quality measurement and payment and risk structure.

A CAG-based APM could be defined to bring together many specialties involved in all aspects of prevention and care of a specific condition in mature delivery systems, or scaled down to focus on specific individual service lines or episodes where the fewest number of distinct specialties and providers share risk when needed. These models of CAGs, chapters and episodes as APMs could further be incorporated into population health APMs or ACOs in the future.

The APM model's flexibility in design allows for specific aspects of care to be added or removed from the framework of the APM models to meet the needs of different specialties, practice models or settings without being overly burdensome on CMS to administer. This multi-level approach may also be necessary to meet MACRA requirements for greater than nominal financial risk. Areas of medicine with greater variability could more easily meet financial risk requirements at the episode level, while those who have low variation could band together to improve care for a population. This is just one type of risk and we will continue to advocate for CMS to consider the interaction of multiple types of risk (including actuarial, operational and financial risk) when defining the APM risk requirement.

Another vital consideration in making this project a success will be access to data. As in MIPS, data from multiple pertinent clinical data sources and registries will need to be made readily available to inform physician decisions. This data will be used in conjunction with advanced analytic tools and techniques that measure and drive accountability and improvement.

Recently we have also challenged our project team to combine the various episodes, chapters or CAGs engaged in by a single physician, and combine them into a "cluster" which is essentially the bundle of bundles for that provider. In this model a given physician would have their performance in each type of care measured against other similarly situated providers for each type of care provided. This could allow for more objective and meaningful measurement, and combined with the multiple levels of APM described above, could help providers to reach the percent of care thresholds required to be qualified APM participants.

There are a number of other concerns that will need to be addressed as our project matures such as designating the payment mechanism and entity and balancing actuarial, operational and financial risk in a way that meets MACRA requirements without overburdening potential participants. Risk based contracting and risk based capital needs are critical to cover unexpected losses and allow for business sustainability. For surgeons and other physicians, MACRA readiness will involve risk management, clinical operational readiness and fiscal readiness.

Due to the short timeframe for implementation, ACS and other societies have had to begin work on APMs prior to release of the rule implementing MACRA in order to have models available in time for their members to participate in early years. As our work continues, much uncertainty remains and many unanswered questions exist. For example, what regulations, if any will be promulgated on stop-loss and premium support for re-insurance? Also while Congress intended to create a clear pathway for development of physician focused APMs that would qualify under MACRA, CMS and CMMI are under no statutory obligation to move forward with any models recommended by the PTAC. Therefore, not only are models being developed with limited guidance, there are also no assurances that models approved by the PTAC will ultimately be adopted by CMS.

This project is still very much a work in progress but we are making steady headway with the team at Brandeis and the Center for Surgery and Public Health at the Brigham and Women's Hospital and our partners in multiple surgical specialties. ACS is committed to making MACRA a success and is providing periodic updates to CMS and stakeholders as our project moves forward. We appreciate the Committee's commitment to the reforms started with MACRA and we thank you for this opportunity to provide input as the process continues.

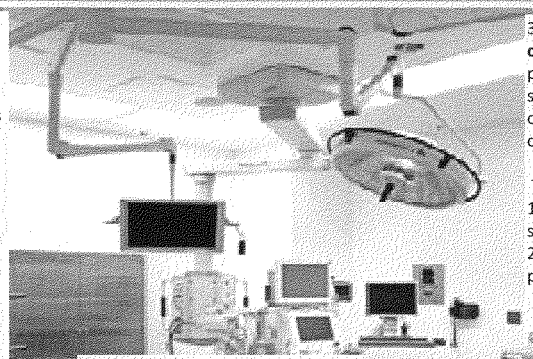
Sincerely,

[redacted]

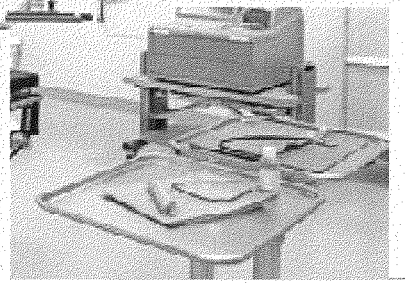
David Hoyt, MD, FACS
Executive Director

1. Alignment of surgical treatment plan and **patient goals of care:** percent of patients who have been given the purpose for the recommended procedure AND goals of care have discussed and documented in the medical record

Purpose of the procedure:
1. Establish a diagnosis
2. Relieve symptoms
3. Treat underlying condition
4. Improve function and/or QoL



2. Identification of **major co-morbid medical conditions:** Percentage of patients undergoing a surgical procedure who received general or spinal anesthesia and who has documentation of significant co-morbid condition(s) in their medical record



3. **Modifiable risk factor, smoking cessation:** percentage of smoking patients who receive tobacco screening and are offered counseling of delaying procedure until smoking cessation is achieved

Two steps to the measure:
1) Identify that the patient is a smoker
2) Refer the patient to a cessation program

4. **Pre-op key medications review for anticoagulation medication**: percentage of patients undergoing anesthesia who are on anticoagulation medication(s) and who are given a perioperative management plan for anticoagulation medications
5. **Patient Centered Risk Calculator:** http://riskcalculator.facs.org/ As part of shared decision making, provide patient with preop risk calculator for expected outcomes.
6. **Patient frailty or functional index** : percentage of patients 65 years and older who underwent a non-emergency surgery and were evaluated using a frailty index score or a functional status score
(this can include multiple tools)
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7. **Perioperative composite**: percentage of patients who underwent surgery and the current status of updated Hx and Phys, re-evaluation of critical studies, documentation of site and side are documented in the medical record.
8. **Post-op care coordination and follow-up:** percentage of patients who underwent a major surgery with appropriate anesthesia who had their results **communicated to the patient's PCP or referring physician within 30 days** of the procedure via telephone, EHR, or written letter, with appropriate documentation in the medical record.
9. PQRS # 356 Unplanned Hospital **Readmission within 30 Days** of Principal Procedure
10. Participation in a **national risk adjusted outcomes** surgical registry.
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Highest Standards, Better Outcomes

Sound Policy. Quality Care.

Statement of the Alliance of Specialty Medicine on MACRA Implementation
before the
Subcommittee on Health of the Committee on Energy and Commerce
of the U.S. House of Representatives
Tuesday, April 19, 2016

The Alliance of Specialty Medicine (Alliance) is a coalition of national medical specialty societies representing more than 100,000 physicians and surgeons. We are dedicated to the development of sound health care policies that foster patient access to the highest quality specialty care. The Alliance appreciates that Congress devoted a portion of the Medicare Access and CHIP Reauthorization Act (MACRA), P.L. 114-10, to streamlining existing federal quality reporting mandates, addressing obstacles that currently prevent specialists from participating meaningfully in these programs and reducing the amount of physician payment at risk. We also appreciate that MACRA affords specialty societies the opportunity to work closely with CMS to determine how best to interpret the law.

In preparation for MACRA implementation, Alliance societies have been educating their members about the Merit-Based Incentive Payment System (MIPS) and participation in Alternative Payment Models (APMs) and gathering feedback on the most pressing policy and operational implications for specialty medicine. We look forward to sharing additional insights with Congress and the Centers for Medicare & Medicaid Services (CMS) as we continue to collect this information. In the interim, we would like to share specialty medicine's overarching recommendations and most pressing concerns.

Our specific principles and concerns about MIPS and APMs are outlined below:

Merit-based Incentive Payment System (MIPS)

- **Gradual, thoughtful implementation will be the key to success**. The Physician Quality Reporting System (PQRS), the Electronic Health Record (EHR) Incentive Program and the Value-Based Payment Modifier (VM) were all well-intentioned programs but implemented via strategies that were flawed on many levels. As a result, these programs were unnecessarily burdensome and produced largely meaningless data. There is a real fear that policymakers will maintain the flawed features of these programs and simply combine them under a dysfunctional system that differs in name only. Version 1.0 of MIPS cannot simply become Version 2.0 of the PQRS, EHR Incentive Program and the VM. MIPS represents a critical opportunity to press the reset button on current programs — to take a careful inventory of what is and what is not working for both patients and physicians, and to use those experiences to correct things that might not have been carried out appropriately in the past. However, building a new quality infrastructure will require a thoughtful and gradual approach to ensure that the initial transition to this new system is as seamless and undisruptive to clinical practice as possible. This will include balancing the need to maintain certain elements of current programs that physicians find suitable and are familiar with while abandoning the most critically flawed features and testing alternative strategies that allow physicians to demonstrate value in more innovative ways. To date, CMS has done little to evaluate whether existing federal mandates have had a meaningful effect on quality improvement across physician specialties.

- **Flexibility will ensure meaningful engagement**. When developing MIPS policies, it is critical that CMS take a flexible, rather than prescriptive, one-size-fits-all approach. Ensuring that MIPS is

relevant to all specialties will help to not only ease the transition to this new system but will also foster innovation, trust and ultimately widespread stakeholder engagement.

- **Investment in measure gaps must occur expeditiously**. For many specialties, the most significant barrier to meaningful participation in current programs is an ongoing lack of relevant measures. CMS must expeditiously support — through financial investments, technical assistance, and greater access to data — the development of high-quality, specialty-focused measures to ensure that all physicians have a fair opportunity to demonstrate quality and value for the unique conditions and populations they treat. The paucity of relevant resource use measures is especially critical. Few, if any, specialties have been able to identify resource use measures suitable for accountability. Cost profiles are difficult to create for the individual provider, requiring the development of complex risk adjustments and attribution methodologies and open access to all-payer data. While CMS and its contractors have been working for many years to develop more granular episode-based resource use measures, they are not expected to be ready in time for the initial performance year of MIPS. As a result, CMS will need to adopt a contingency plan that reflects the current state of measurement. To ensure that physicians are not inappropriately penalized, this plan should include a re-weighting of the resource use category of MIPS until these challenges are resolved. It is equally critical that CMS retire the current flawed resource use measures used under the VM, which were not developed with physician input and hold specialists accountable for care provided outside of their control, and if necessary, consider surrogate metrics in the interim, such as those that evaluate appropriate use. In general, resource use measures should not have an adverse impact on practice patterns or discourage treatments that best meet the needs of individual patients. For example, CMS' current resource use methodology is constructed in a way that disincentivizes the use of Part B drugs over Part D drugs, which can interfere with treatment decisions and patient preferences.

- **Meaningful use must be redefined**. Current strategies for incentivizing meaningful use of EHRs are impractical and unsustainable. Many of our societies' members continue to struggle to satisfy the requirements of the Electronic Health Record (EHR) Meaningful Use program because the measures are of little relevance to specialists and the unique patient populations they serve. The technology, itself, also remains cumbersome and unresponsive to specialists' needs, and interoperability persists. As a result of these ongoing challenges, specialty physicians find that the current meaningful use requirements slow down their workflow, create documentation burdens that result in minimal care improvements, and distract physicians from patient care. It is time for CMS to completely restructure incentives for meaningful use of EHRs so that physicians, as well as vendors, focus less on compliance and box checking and more on truly transforming care. Going forward, meaningful use mandates must ***not*** rely on all-or-nothing, pass-fail strategies. Instead, they should account for varying practice circumstances and varying levels of physician control over EHR choice and functionalities by rewarding incremental effort toward program goals. Physicians should not be penalized for standards that EHRs cannot yet achieve. We also believe that neither MIPS nor APMs can succeed without a more strongly enforced national mandate for genuine and widespread interoperability. We urge CMS to work closely with its federal agency counterparts on solutions that will help ensure seamless, bi-directional information exchange — across all health information technology systems and clinical data registries — without additional cost to those eligible professionals and practices that make an investment in certified electronic health record technology.

- **Continue to promote the value of clinical data registries**. We strongly support CMS' investment and promotion of qualified clinical data registries (QCDRs) to date. We support policies that continue to recognize the value of registries, that permit physicians to meet multiple components of MIPS by participating in a QCDR, that promote interoperability between registries and EHRs, and that provide registries greater access to private and payer claims data.

- **Clinical practice improvement activities**. MACRA created this new category under MIPS to recognize physicians for engaging in quality improvement activities that do not necessarily lend themselves to traditional performance measurement, such as continuing medical education, maintenance of certification, expanded office hours and the use of clinical data registries. It is critical that CMS preserve the intent of this innovative and long sought after provision by recognizing a wide variety of activities that represent the unique needs of each specialty. As part of this process, we support giving professional societies the authority to determine which activities should count for their specialty and how best to evaluate and score physician compliance with those activities. Similarly, individual physicians should have the flexibility to choose activities that are most relevant to their practice, should not be required to satisfy any specific subcategory of activities and should be able to readily attest to compliance with such activities.

- **Monitor the regulatory burden of these new programs**. A recent study in *Health Affairs* demonstrates that physicians are spending more than $15 billion each year on quality reporting. Other research published in leading journals — including the prestigious *New England Journal of Medicine* — has shown that the focus on the way Medicare is measuring quality is off-track and is turning physicians into meaningless information box-checkers. Over both the short and long term, it is critical that policymakers carefully monitor the regulatory burden of these new policies on practicing physicians to ensure that compliance does not result in meaningless engagement, wasted resources or otherwise interfere with patient access to personalized care. The MIPS program is intended to simplify quality mandates — not make them more complicated. We remind the subcommittee that the final regulations detailing the initial implementation of MACRA policies will not be released until the fall of 2016, only months before the start of what we expect to be the first performance year. It is, therefore, critical that CMS implement policies, educational tools and other forms of support to accommodate physicians during this transition period and to ensure they are not unfairly penalized due to a lack of time to understand and comply with new rules.

APM Implementation

- **Flexibility is essential for specialties and subspecialties to develop and implement APMs for their specific patient population and practice types.** CMS' recent Request for information (RFI) on MACRA implementation seemed to suggest that the agency planned to focus on only a handful of existing models, most of which do not apply to our specialties. Similarly, we have heard that the few APMs developed to date by specialty societies are too narrow in focus because they are centered on a particular disease, condition or set of procedures. We strongly urge CMS to provide maximum flexibility in considering new models that have not previously been tested. Furthermore, the agency needs to provide the resources and technical assistance to get those models off the ground. Rather than being overly prescriptive, CMS should identify key elements that must be inherent to any APM while leaving it open to APM developers to determine how each of the key elements should be met by eligible professionals under the model. CMS' overall policy should recognize a diverse selection of APMs so that physicians can choose those that are most relevant to their patient population and most appropriate for their practice.

  In addition to flexibility, policies to encourage more widespread APM participation among specialists must carry minimal administrative burden for both physicians and patients, maintain patient access to specialty care and choice of provider, and recognize patient diversity. We also continue to urge CMS to carefully consider its definition of "more-than-nominal" financial risk. Financial risk for physicians comes in many forms, including investments in human capital — clinical and administrative — technological infrastructure, clinical workflows and patient case-mix. Similarly, CMS must adopt revenue threshold policies that do not preclude specialists from becoming a "qualifying" APM participant. Several Alliance specialty organizations have developed or are developing, APMs for various procedures and conditions. However, in most instances, a specialist would not meet the revenue threshold by engaging in only one condition or procedure

specific APM developed by their specialty organization. Therefore, we encourage CMS to recognize, in the aggregate, participation in multiple APMs.

- **Ensure recognition of physician-focused payment models**. The Alliance appreciates that Congress included in MACRA a particular focus on physician-designed and developed models through expertise provided by the newly established Physician-Focused Payment Model Technical Advisory Committee (PTAC). However, specialists are concerned about the limited role of the PTAC. CMS is under no obligation to recognize models recommended by the PTAC, and the Center for Medicare and Medicaid Innovation (CMMI) has recently signaled that it will not necessarily test the physician-focused payment models that are advanced by the PTAC. These policies are concerning to the Alliance since they could significantly disadvantage specialists — most of which continue to lack relevant APMs — by leaving them with few options to participate in this track. The Alliance continues to urge CMS to give due consideration to APMs recommended by the PTAC, as well as by individual specialty societies, to provide specialists with the opportunity and incentive to participate in more transformative payment and delivery models.

- **Thoughtful consideration of APM implementation timeline to minimize physician burden and confusion**. The Alliance is concerned about the timeline carved out for the APM track. Under MACRA, the first APM payment update is scheduled for 2019. It is important that CMS administer the 2019 APM payment update in a way that allows physicians who are qualified APM participants to forego participation in MIPS in 2017. Otherwise, physicians will need to assume they must comply with the 2017 MIPS reporting requirements because they will not yet know whether they satisfied the 2019 APM payment update requirements. This timeline issue is important in the initial years of MACRA implementation, but also over the long-run.

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In summary, the Alliance of Specialty Medicine supports efforts to improve the quality and overall value of health care. It is essential, however, that programs are meaningful to specialty physicians and their patients, driven by relevant clinical expertise, carefully evaluated for feasibility and provide physicians with the flexibility to choose activities that are most appropriate for their practice. Physicians should not be held accountable for increasingly challenging and clinically irrelevant federal reporting and performance mandates. We encourage policymakers to take advantage of this opportunity to construct a better, more meaningful quality infrastructure and to do so in a transparent manner that respects the MACRA mandate to engage directly with physician stakeholders.

Thank you for the opportunity to provide our views for the record. We encourage Congress to continue to exercise its oversight role as CMS implements these new Medicare payment systems.

American Academy of Facial Plastic & Reconstructive Surgery
American Association of Neurological Surgeons
American College of Mohs Surgery
American Gastroenterological Association
American Society for Dermatologic Surgery Association
American Society of Cataract and Refractive Surgery
American Society of Echocardiography
American Society of Plastic Surgeons
American Urological Association
Coalition of State Rheumatology Organizations
Congress of Neurological Surgeons
North American Spine Society
Society for Cardiovascular Angiography and Interventions

Julie Vose, MD, MBA, FASCO
President
American Society of Clinical Oncology

Statement prepared for:
House Energy & Commerce Committee
Subcommittee on Health

Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

April 19, 2016

The American Society of Clinical Oncology (ASCO) is pleased to submit this statement in connection with the hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms." ASCO is grateful to the Energy & Commerce Committee, particularly to this subcommittee, for their work to develop MACRA. We provided extensive feedback to you during development of the legislation, which we publically supported and promoted.

The collaborative environment you created resulted in overwhelming bipartisan support in both the House and Senate. As a part of the provider community, we appreciate this important step toward a more rational payment system and feel ownership over this as well. ASCO will continue to work with you and CMS to ensure this legislation works for oncology providers and their Medicare patients.

The emphasis on quality and value that underpins MACRA is entirely consistent with ASCO's mission and work. For more than a decade, we have been focused on delivery of high quality, high value care for every patient with cancer. Our longstanding performance measurement system, QOPI, is a qualified clinical data registry, which has a high degree of support and participation among our members. It is even beginning to penetrate international practices. We also are well on the path to building a rapid learning system for oncology, called CancerLinQ, which we believe will revolutionize cancer care. We are hopeful that these important systems can thrive under MACRA.

We support MACRA's emphasis on value over volume. ASCO is very focused on the cost of cancer care and what it means for patients with cancer. We have developed a wide range of education and related tools that support and encourage patient-physician conversations about the cost of their care. We also have a robust portfolio of clinical guidance for physicians, including a value framework designed to inform and support shared decision-making and the selection of high value care options.

ASCO's Alternative Payment Model

ASCO is encouraged by MACRA's strong emphasis on alternative payment models, and particularly the acceptance of those developed by physicians. ASCO has been developing and refining

an APM for oncology since 2010. Our model, the Patient Centered Oncology Payment Model (PCOP), would fundamentally restructure the way cancer care is paid for and better align those payments with the patient services that are critical to delivering quality care.

PCOP was developed by a dedicated group of ASCO volunteers, who met every other week for two years. The group included medical oncologists from diverse practice settings, seasoned practice administrators, and experts in physician payment and business analysis. In addition to the input from outside experts in clinical and economic aspects of cancer care, ASCO used data from sources such as the National Practice Benchmark for Oncology and interviews with a representative sample of oncology practices to estimate the amount of time and money oncology practices are currently spending to deliver services to oncology patients—services that are not adequately supported by existing fee-for-service payments for office visits and medication administration.

Our PCOP model would also test many of the policy alternatives that have gained visibility recently, including bundled payments and episode-based reimbursement. ASCO has estimated that PCOP would increase or keep whole payments for oncology practices, while still yielding savings to the Medicare program. These savings arise through better matching of payments with actual care delivery that enables practices to organize care in a way that helps patients avoid expensive hospitalizations and unnecessary tests and treatments.

We believe that PCOP will qualify as an APM under MACRA because it meets the stated criteria in the law: includes quality measurement, more than nominal financial risk, requires the use of certified EHRs, and includes financial incentives. CMMI has its own model for oncology, the Oncology Care Model, which some have argued should suffice for oncology. We disagree and don't believe that is consistent with your intent when you developed and passed MACRA.

ASCO is grateful for the path outlined in MACRA for physician developed APMs. We are aware the Physician Focused Payment Model Technical Advisory Committee (the TAC) is just forming, but are hopeful it provides—as you intended—a meaningful opportunity for review and approval of high quality APMs like ASCO's PCOP. If this path does not work as intended, we hope that Congress will intervene.

Preparing Our Members for MACRA

ASCO is utilizing all the communications vehicles we have available to educate and inform our members about MACRA, and prepare them for implementation. We have a group of volunteers and leaders who meet every other week to assist our members in planning for MACRA. Through these efforts, we hope that oncologists can be among the best prepared specialists in the nation. While our hopes remain high that multiple APMs will be available for oncology, we know that many, if not most, of our US members will be in the Merit Based Incentive Payment System (MIPS). To that end, we are encouraging participation in Meaningful Use, Physician Quality Reporting System, and ASCO's own Qualified Clinical Data Registry. We are also ensuring that our physicians understand the relatively new Physician Value-Based Payment Modifier (VBM) given its significance for Resource Use, Clinical Practice Improvement Activity and measure development.

To help educate our members, we've held full day seminars at our office in Alexandria, VA, nationwide webinars, presentations at state society meetings, and presented at ASCO's annual meeting.

This allows all of our members to have an opportunity to receive training on MACRA implementation. We have recruited a dedicated Task Force of ASCO's highest committee leadership to work on implementation and view it from broad perspectives. Additionally, we've conducted practice readiness assessments at individual sites to help practices understand what steps they will need to take ahead of MACRA implementation.

When appropriate, we will share APM information and help prepare membership for participation in all APMs available in oncology.

Engaging with CMS to Make MACRA Work for Oncology

ASCO has provided feedback to CMS on a number of aspects of implementation of specific importance to oncology. Although we support the transition to value-based payment, we remain concerned that the MIPS methodology for measuring resource utilization could unfairly penalize oncologists who provide care that is medically necessary, but also high cost. These are costs that are completely outside of their control. Currently, CMS assesses resource use through the Value-Based Payment Modifier (VBM), which provides too blunt an instrument to protect and promote quality in oncology. To be successful in implementing MACRA, policymakers must learn from and avoid the mistakes made in implementing the VBM.

The treatment of cancer is both clinically complex and highly specialized, creating many factors that must be considered to accurately evaluate medical oncology resource use in a way that protects the interests of patients. There are more than 120 different types of cancer (and through advances in molecular diagnostics, this list is growing), and the most appropriate treatment option for a particular patient often involves the administration of a multi-drug regimen. In a growing number of instances, the selection of the most appropriate anticancer drug for an individual patient is based on molecular factors that predict superior outcomes using increasingly expensive targeted agents that lack equivalent alternatives. In these ever more common scenarios, the medical oncologist is left with little flexibility to reduce drug utilization costs by selecting lower cost alternatives. It is counterproductive to assess a provider's resource use based on Part B or Part D drug expenditures that are outside of their control in this way.

Congress and CMS must not assume that variations in resource needs among patients and medical oncology providers will "average out" over time. It is increasingly common for medical oncologists even in the community setting to specialize in treating particular types or sub-types of cancer. There are some physicians and many oncology practices that specialize in treating the most complex—and often most costly—oncology patients. In some of those instances, there will be significant differences in resource consumption compared with other providers. We are especially concerned that if resource use measurement does not account for these clinical differences, CMS may inadvertently unfairly penalize practices and create access barriers for patients with complex and molecularly unique forms of cancer. Congress and CMS should take this situation into consideration for

any process used to measure resource use in oncology and should not implement such a process until there is confidence the methodology will adequately protect quality and access to care for patients with these complex illnesses.

Given the factors described above, and because drug pricing is entirely outside of the control of treating physicians, ASCO recommends that Congress and CMS adopt a more nuanced approach for oncology than simply comparing aggregate drug costs under Medicare Part B and Part D. Congress and CMS should exclude the use of raw drug expenditures in resource use determinations. Instead, CMS should assess drug resource use by evaluating adherence to evidence-based, value-based medical decision-making. ASCO endorses the use of high-quality clinical pathways in oncology as a mechanism to assess the provision of such care.

Appropriately designed clinical oncology pathways are detailed, evidence-based treatment protocols for delivering quality cancer care for specific patient presentations, including type and stage of disease. Clinical oncology pathways are a tool that can be used to appropriately align incentives for cancer patients and providers for resource use assessment in cancer care. Oncology pathways are being used by an increasing number of private payers to ensure evidence-based, value-based care for cancer patients. Used in this way, clinical oncology pathways can enable oncologists, payers, and patients to provide assurances that patients are receiving clinically appropriate therapies without unnecessary costs, including drugs. Oncology pathways balance the considerations of clinical efficacy, safety, toxicities, cost, and scientific advances, including the growing personalization of therapy based on molecular diagnostics.[1] Simply put, clinical pathways help to ensure that the right patient gets the right care at the right time. Since compliance with appropriately designed oncology pathways define optimal care, medically appropriate concordance with pathway programs that have been developed and peer-reviewed by oncologists should be considered a major quality indicator.

In addition to drug costs, ASCO has serious concerns that CMS is failing to implement adequate risk adjustment to assess resource use in a way that fairly addresses differences in resource use among oncologists. Cancer care is incredibly complex and growing more so with each passing year, and the costs of cancer care are highly variable depending on a patient's diagnosis, cancer stage, molecular markers, geographic access to care, comorbidities and other clinical factors. In light of these complexities, it is imperative that CMS develop a risk adjustment methodology that will be specifically used to address cancer care. Traditional administrative claims data alone are insufficient to provide a desirable risk-adjustment methodology. Without the clinical information routinely collected in a Pathway Program, risk adjustment for outcomes or costs will be impossible.

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[1] Zon RT, Frame JN, Neuss MN, Page RD, Wollins DS, Stranne SK, Bosserman LD. American Society of Clinical Oncology policy statement on clinical pathways in oncology. Journal of Oncology Practice. 2016 [epub ahead of print].

We urge Congress to provide oversight in this area to ensure that medical oncologists are not subject to unfair resource use measurement due to the clinical complexity of the patient populations they serve.

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Thank you for your leadership on passage and continued oversight to ensure successful implementation of MACRA. We look forward to continued work with you and your staff's to ensure that Medicare beneficiaries have access to oncology services moving forward. Please contact Amanda Schwartz at Amanda.Schwartz@asco.org with any questions.

April 19, 2016

The Honorable Joe Pitts
Chairman
House Energy and Commerce Committee
Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Gene Green
Ranking Member
House Energy and Commerce Committee
Subcommittee on Health
2322 A Rayburn House Office Building
Washington, DC 20515

RE: Advanced Practice Registered Nursing (APRN) Organizations Comment for April 19, 2016, Hearing of the House Energy and Commerce Subcommittee on Health, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms"[1]

Dear Chairman Pitts, Ranking Member Green and Members of the Subcommittee:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs), we provide the following statement for the record in support of the Subcommittee's hearing on April 19, 2016, titled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

As strong supporters for the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), our statement:

- Summarizes the role of America's 350,000 APRNs in the Medicare program;
- Outlines activities APRNs have undertaken to implement MACRA, in particular its Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) provisions;
- Describes concerns that APRNs have had with implementation processes thus far; and,
- Recommends solutions.

America's 350,000 APRNs Provide Excellent Care Where Care is Needed Most, Enhancing Value for Patients and Access to their Medicare Benefits

The APRN community is comprised of organizations representing Nurse Practitioners (NPs) delivering primary, acute and specialty care; Certified Registered Nurse Anesthetists (CRNAs) who provide the full range of anesthesia services as well as chronic pain management; Certified Nurse-Midwives (CNMs) expert in primary care, maternal and women's health; and Clinical Nurse Specialists (CNSs) offering acute, chronic, specialty and community healthcare services.

[1] Hearing background information at https://energycommerce.house.gov/hearings-and-votes/hearings/medicare-access-and-chip-reauthorization-act-2015-examining-physician, retrieved Apr. 18, 2016.

Totaling more than 350,000 healthcare professionals, including two of the ten largest categories of Medicare Part B provider specialties according to Medicare claims data, our primary interests are patient wellness and improving patient access to safe and cost-effective health care services. In every setting and region, for every population particularly among the rural and medically underserved, America's growing numbers of highly educated APRNs advance healthcare access and quality improvement in the United States and promote cost-effective healthcare delivery.

When we expressed our support for MACRA, our comments to Congress stressed the importance of full participation of APRNs including the treatment of APRNs the same as physicians in the development, vetting, implementation and evaluation of quality measures and incentive reimbursement programs, and in the application of alternative payment models. We stated that Congress' bipartisan, bicameral legislative approach met those objectives in the interests of patient safety and of beneficial market competition for patient-centered innovations in healthcare delivery.

While we are grateful for the opportunity to provide testimony for the record, we recommend that the Subcommittee in the future consider inviting APRN witnesses to testify in the same way it invites representatives of physician organizations. APRNs are critical to patients, to the delivery of the Medicare program, and to the implementation of MACRA. CMS data from January 2016 indicate that 205,038 APRNs were enrolled as Medicare Part B providers. Additional APRNs who are employed by hospitals or work in Medicare Advantage plans and treat Medicare patients may not be enrolled as Part B providers. One in nine enrolled Part B providers is an APRN. Nurse practitioners are the third largest specialty in Part B after internists and family practitioners. CRNAs are the sixth largest specialty in Part B and outnumber anesthesiologists.[2] While APRN services are provided coast-to-coast among all patient populations, they are particularly crucial to populations that are rural or medically underserved, that have lower incomes than the national average, and that are more likely to be beneficiaries of Medicare, Medicaid or subsidized plans.

While APRN Organizations have Engaged in MACRA Implementation Activities, Improvements Can be Made in Ensuring the Views of All Part B Providers are Fairly Considered

APRN organizations have engaged at many levels in regulatory and policymaking processes associated with MACRA implementation, especially with respect to the MIPS and APMs provisions. These activities have included:

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[2] Report on 2013 PQRS results posted by CMS at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html. Raw data identifying Part B providers posted by CMS at https://data.cms.gov and https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-22.html. Numerical analyses conducted by Peter McMenamin, PhD, Health Policy Department, American Nurses Association, Aug. 13, 2015, and March 7, 2016, respectively.

- Developing and submitting comments to the FY 2017 physician fee schedule notice-and-comment regulatory rulemaking progress. Specific MACRA-related requests included:
    - Supporting equal treatment across provider groups in the development, evaluation and implementation of Clinical Practice Improvement Activities (CPIA) portion of the MIPS score;
    - Ensuring that APM "physician-focused payment models" treat APRNs the same as physicians in the delivery of the same services to patients, while being renamed "provider-focused payment models;"
    - Supporting Medicare recognition of APRNs to their full scope of practice as a valuable factor in developing and implementing APMs; and,
    - Ensuring all language associated with MACRA implementation is provider-neutral.

- Developing and submitting comments to the U.S. Department of Health and Human Services MACRA implementation request for information process. Specific MACRA-related requests included:
    - Supporting integrating APRNs into processes for development, implementation and evaluation of MACRA-driven payment and care delivery models;
    - Ensuring that each service provided to a patient is associated with the actual provider of the service, in relation to the MIPS eligible providers (EP) provisions;
    - Ensuring that all performance mechanisms be subject to all stakeholders' transparent and public review and comment in order for them to qualify as reporting mechanisms for MIPS and APM quality indicators;
    - Supporting the fairness and accuracy of all measures associated with MIPS and APMs so that they do not impair or eliminate competition from among safe and qualified healthcare providers;
    - Excluding from quality measures the issue of whether an EP is a participant in the network of plans in a Federally Facilitated Marketplace, since such a determination is not entirely within the EP's control;
    - Ensuring equal treatment among APRNs and physicians in the development, implementation and evaluation of CPIAs;
    - Including APRNs within the development, implementation and evaluation of Physician Focused Payment Models the same as physicians;
    - Engagement of healthcare professionals involved modestly in Medicare, such as pediatric nurse practitioners (who treat children with renal failure awaiting transplantation, and the children of adults with renal failure awaiting transplantation that qualify for Medicare coverage), as Medicare payment policies

adopted through MACRA are likely to migrate into Medicaid, CHIP and commercial health plans; and,

- Supporting APRN full scope of practice as a criterion for evaluating Physician-focused Payment Models. Such policy is recommended by the Institute of Medicine and helps to expand access, advance healthcare quality, and promote cost-effective healthcare delivery.

APRN organizations have also participated in the Healthcare Payment Learning and Action Network (LAN), but have been disappointed that notwithstanding several nominations so few APRNs have been selected by the LAN to coordinate and lead its panels and workgroups. Insufficient engagement of APRNs within LAN risks imperiling the success of payment reform initiatives that the LAN recommends – a critical issue since America's APRNs provide care for hundreds of millions of Americans annually, including the vast majority of the Medicare population. We have also commented on the development and implementation of the Medicare Comprehensive Joint Replacement (CJR) demonstration project, arguably the first major APM established by the agency since the enactment of MACRA, which has been in operation since April 1, 2016.

APRN organizations await the publication of the MIPS and APM implementation proposed rule now under review at the Office of Management and Budget, Office of Information and Regulatory Affairs (OMB OIRA).

From APRN Experience Thus Far, How Might MACRA Implementation be Improved in the Interest of Medicare Patients and Other Critical Stakeholders

From the perspective of APRN organizations, the MACRA implementation record thus far scores a grade of "incomplete," as the executive branch has not yet published a proposed rule implementing the MIPS and APM provisions of MACRA in advance of the approaching statutory deadlines. From the above issues, however, there are several that deserve priority consideration and oversight by the Congress:

1. **It is particularly important for Medicare to implement MACRA in all respects in a manner that incorporates the participation, views and contributions of APRNs the same as it does physicians.** Failing to do so imperils the implementation of these crucial payment reforms which are necessary to our country successfully ensuring access to care for the near-doubling of our Medicare patient population by 2030, just 14 years from now.
2. **Of all factors within MIPS, the Clinical Practice Improvement Activities (CPIA) portion is the least thoroughly developed, and stands to benefit the most from the full involvement and incorporation of APRNs the same as physicians.** To this point, we do not see evidence that Medicare is driving joint development and adoption of

CPIAs among APRN and medical organizations. If the CPIAs are not arranged the same way for different providers performing the same services for the same patient types, then such providers will yield different MIPS CPIA scores and be awarded different payment rewards and penalties – an unjustifiable outcome likely to sow confusion and discontent in the healthcare delivery marketplace and among patients.

3. **Also within MIPS, implementation of the Electronic Health Records – Meaningful Use (EHR-MU) portion should reflect neutrally upon providers such as those APRNs that (a) have been ineligible for EHR incentive payments under the High Tech Act in either Medicare or Medicaid, and/or (b) provide services such as anesthesia where the EHR systems are the responsibility of the facility not the provider.** Providers ineligible or inappropriate for participation in EHR-MU should not be scored lower on MIPS than providers that either by their nature or by act of Congress have been eligible and have been participating in EHR-MU.
4. **As the Department moves forward to implement policies around chronic care coordination we request that these policies be inclusive of APRNs.** As the chosen healthcare provider for their patients, APRNs are in charge of their chronic care coordination. We look forward to continued work with Congress to ensure that all Medicare providers, including APRNs, are able to provide and be reimbursed for this type of treatment.

Thank you for taking time to engage the public and the community of healthcare professionals through your hearing. We remain at your service, especially with respect to the implementation of this critical MACRA statute. If you have any questions, please contact Frank Purcell of the AANA at 202-741-9080, fpurcell@aanadc.com.

Sincerely,

American Association of Colleges of Nursing (AACN)

American Association of Nurse Anesthetists (AANA)

American Association of Nurse Practitioners (AANP)

American College of Nurse-Midwives (ACNM)

American Nurses Association (ANA)

Gerontological Advance Practice Nurses Association (GAPNA)

National League for Nursing (NLN)

National Association of Pediatric Nurse Practitioners (NAPNAP)

National Organization of Nurse Practitioner Faculties (NONPF)

cc: Rep. Fred Upton, Chairman, House Energy and Commerce Committee
Rep. Frank Pallone, Ranking Member, House Energy and Commerce Committee
Members of the House Energy and Commerce Health Subcommittee

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IDSA
Infectious Diseases Society of America

April 15, 2016

The Honorable Joe Pitts
Chairman
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
420 Cannon House Office Building
Washington, DC 20515

The Honorable Gene Green
Ranking Member
Subcommittee on Health
Energy and Commerce Committee
U.S. House of Representatives
2470 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Green:

On behalf of the Infectious Diseases Society of America (IDSA), I write to thank you for scheduling the hearing, "Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms," for April 19. IDSA greatly appreciates the Subcommittee's leadership in repealing the Medicare Sustainable Growth Rate (SGR) formula and in overseeing efforts to implement MACRA. IDSA continues to provide input to the Centers for Medicare and Medicaid Services (CMS) on key implementation issues and to work with our members to prepare for payment reforms.

We are pleased to share with the Subcommittee some of our concerns regarding the impact of MACRA implementation and physician reimbursement on the future of the Infectious Diseases (ID) specialty, our ongoing efforts in this area, and our policy recommendations. Specifically, we request the following:

- **Direct CMS to adopt a broad interpretation of the Clinical Practice Improvement Activities (CPIA) within the Merit-Based Incentives Payment System (MIPS);**
- **Direct CMS to allocate MACRA funding for infectious diseases quality measure development; and**
- **Direct CMS to conduct the research needed to appropriately revalue current evaluation and management (E&M) billing codes.**

We hope this information will be of use to the Subcommittee as you continue your oversight activities, and we look forward to continuing to engage with you on these important issues.

The Value of ID Physicians

ID physicians make significant contributions to patient care, biomedical research, and public health. Their leadership saves lives, prevents costly and debilitating diseases, and drives biomedical innovation. ID physician involvement in patient care is associated with significantly lower rates of mortality and 30-day readmission rates in hospitalized patients, shorter lengths of hospital stay, fewer intensive care unit (ICU) days, and lower Medicare charges and payments. Unfortunately, a

decline in the number of physicians pursuing ID as a career is jeopardizing the future of this specialty and putting patients at risk of losing access to these cost-saving ID physician services, including:

- Providing life-saving care to patients with serious infections (such as HIV, sepsis, infections caused by antibiotic resistant bacteria, *Clostridium difficile*, and hepatitis C);
- Leading public health activities to prevent, control, and respond to outbreaks in healthcare settings and the community and emerging infections such as Ebola and Zika virus infections;
- Leading antibiotic stewardship programs to optimize the use of antibiotics to achieve the best clinical outcomes while minimizing adverse events, limiting the development of antibiotic resistance and reducing costs associated with suboptimal antibiotic use;
- Monitoring and managing highly complex patients with or at risk of serious infections (including organ and bone marrow transplant patients, chemotherapy patients, and others); and
- Conducting research leading to breakthroughs in the origin and transmission of emerging and re-emerging diseases, factors that make these virulent, and the development of urgently needed new antimicrobial drugs and other therapies, diagnostics, and vaccines.

Steep Decline in Physicians Entering ID
Data from the National Residency Match Program (NRMP) indicate a disturbing decline in the number of individuals applying for ID fellowship training, with 342 applicants in the 2010 – 2011 academic year and only 254 in 2014 – 2015. For 2016 – 2017, **only 65% (or 218 out of 335) of available ID fellowship positions filled**. In many specialty areas, all, or nearly all, available fellowship positions are typically filled. These data indicate a broader problem—the undervaluation of ID.

ID Reimbursement Concerns
In 2014, IDSA surveyed nearly 600 Internal Medicine residents about their career choices. While results have not yet been published, we can share that very few residents self-identified as planning to go into ID. A far higher number reported that they were interested in ID but chose another field instead. Among that group, **salary was the most often cited reason for not choosing ID.**

Average salaries for ID physicians are significantly lower than those for most other specialties and only slightly higher than the average salary of general Internal Medicine physicians, even though ID training and certification requires an additional 2 – 3 years. Young physicians' significant debt burden ($200,000 average for the class of 2014) is understandably driving many individuals toward more lucrative specialties, often with faster paths to practice.

Despite the significant and vital contributions ID physicians make to patient care, research, and public health, their work continues to be undervalued. Over 90% of the care provided by ID physicians is accounted for by evaluation and management (E&M) services. These face-to-face, cognitive encounters are undervalued by the current payment systems compared to procedural practices (e.g., surgery, cardiology, and gastroenterology). This accounts for the significant compensation disparity between ID physicians and specialists who provide more procedure-

based care, as well as primary care physicians who provide similar E&M services but who have received payment increases simply because of their specialty enrollment designations as "primary care physicians." Cognitive E&M services comprise a higher percentage of services provided by ID specialists than those provided by primary practice specialists such as Internal Medicine, Family Medicine or Pediatrics, based on CMS data.

MACRA Implementation: Opportunities and Challenges
IDSA is excited for the opportunities that MACRA implementation presents to realign physician payment to truly incentivize high quality care. In order for the promise of MACRA to be realized, **we urge the Subcommittee to direct CMS to recognize a wide variety of activities and payment models that are relevant to physicians in different specialties and a wide variety of practice settings and avoid a one-size-fits-all approach that limits meaningful participation by many specialists in federal quality reporting and improvement programs** (as is currently the case for ID physicians with the Physician Quality Reporting System (PQRS)).

Clinical Practice Improvement Activities (CPIA) under the Merit-based Incentive Payment System (MIPS)
This component of MIPS offers a great opportunity for physicians to be recognized for innovative quality improvement activities that significantly impact patient outcomes but may not necessarily easily fall into a "quality metric box." **Given the diverse array of activities that we believe should qualify as CPIAs, we urge the Subcommittee to support a broad interpretation of CPIAs. In order to appropriately capture the many activities needed in order to meaningfully improve patient care, CPIAs should be based upon completion or ongoing participation in activities measured by a specified number of activities rather than hours.** Below are a few potential CPIA examples that could be utilized by ID physicians and would greatly benefit our patients and public health:

- Implementation and/or on-going leadership of an antimicrobial stewardship program
- Implementation and/or on-going leadership of an infection prevention program
- Development of disaster preparedness-related protocols (i.e. facility/system-level Ebola response programs)
- Leadership of health care worker and/or population-based immunization programs
- Implementation and/or on-going leadership of a hospital-avoidance and timely discharge program enabled through outpatient parenteral antimicrobial therapy (OPAT)
- Development of treatment protocols for solid organ transplant cases
- Liaison activity related to hospital/health system engagement with local public health entities

The goal of the CPIA component of the MIPS is to reward eligible professionals who keep up-to-date on best practices and are actively engaged in clinical improvement. As CPIAs can differ across specialties, we urge the Subcommittee to encourage CMS to defer to specialties' interpretations of the CPIA component.

Support for Quality Measure Development Relevant to ID
The current paucity of quality measures relevant to ID have made it extremely difficult and often impossible for ID physicians to participate in current federal quality programs. Existing

HIV/AIDS and Hepatitis C measures are useful, but to only a select portion of ID physicians who focus on treating these patients. For ID physicians who are mainly inpatient-based, the paucity of measures is magnified. We remain concerned that the current lack of ID-relevant measures will result in the public's inability to make clear and meaningful comparisons across our specialty and potentially result in inaccurate conclusions about the quality of ID specialists in general. It also has resulted in little actionable data on which our own members can target quality improvement efforts.

IDSA continues to dedicate efforts to developing clinical quality measures relevant to the treatment of infectious diseases. Our efforts include:

- Development of measure concepts for *Staphylococcus aureus* and submission of these measure concepts to CMS in response to the ongoing CMS Call for Measures.
- Development of measures for Appropriate Treatment of MSSA Bacteremia, which were included in the list of new individual quality measures for CY 2016 PQRS.
- Submission of measure concepts to the National Quality Forum's (NQF) Measure Inventory Pipeline in hopes that we may engage other stakeholders in an effort to further develop these and other measures.
- Involvement in a multi-pronged strategy to promote better antibiotic stewardship.

We continue to be proactive in attempting to address the measures gap for ID physicians. However, considerable financial investment is required to see measure development through the full process. In fact, the cost of developing a measure or set of measures can range from $250,000 to $500,000 or even higher depending on the complexity of the measure, the intended use of the measure (internal quality improvement, pay for performance, public reporting, etc.), and the rigor and extent of testing and consensus-based endorsement. We are currently trying to engage other entities that may be willing to assist in further developing ID measures. **However, we urge the Subcommittee to direct CMS to expeditiously allocate funding authorized under MACRA to address current measurement gaps such as for ID.** IDSA has already made this request to CMS, and specifically encouraged CMS to prioritize funding allocation to the development of quality measures for antibiotic stewardship. Given this Subcommittee's longstanding commitment to combating antibiotic resistance, we hope you will help advance this important effort.

Promoting Appropriate Valuation of Evaluation and Management Codes

While not explicitly addressed in MACRA, current E&M codes fail to reflect the increasing complexity of E&M work, which covers the vast majority of ID as discussed above. Without updated, accurate E&M codes, the payment reform activities included in MACRA will have only a limited impact on improving ID patient care and will fail to address the underlying problem of undervaluing ID that is driving fewer young physicians to enter the specialty. ID physicians often care for more chronic illnesses, including HIV, hepatitis C, and recurrent infections. Such care involves preventing complications and exploring complicated diagnostic and therapeutic pathways. ID physicians also conduct significant post-visit work, such as care coordination, patient counseling and other necessary follow up.

IDSA urges the Subcommittee to direct CMS to undertake the research needed to better identify and quantify the inputs that accurately capture the elements of complex medical decision-making. Such studies should take into account the evolving health care delivery models with growing reliance on team-based care, and should consider patient risk-adjustment as a component to determining complexity. Research activities should include the direct involvement of physicians who primarily provide cognitive care. Specifically, this research should:

1) Describe in detail the full range of intensity for E/M services, placing a premium on the assessment of data and resulting medical decision making;
2) Define discrete levels of service intensity based on observational and electronically stored data combined with expert opinion;
3) Develop documentation expectations for each service level;
4) Provide efficient and meaningful guidance for documentation and auditing; and
5) Ensure accurate relative valuation as part of the Physician Fee Schedule.

IDSA remains committed to ensuring a robust ID physician workforce for current and future generations to provide high quality patient care, protect public health and drive biomedical innovation. In addition to developing federal policy recommendations, we are also engaging in numerous other activities, including:

- Sponsoring a study that will evaluate current and existing ID Workforce needs;
- Increasing mentorship and scholarship opportunities at our annual scientific meeting (IDWeek) and throughout the year (including establishing additional ID interest groups at medical schools and strengthening ID curriculum);
- Launching a campaign to educate key audiences, including medical students and residents, on the value of ID physicians; and
- Continuing research to document the value that ID specialists bring to the healthcare system, public health and biomedical research, as well as efforts to share those findings.

Once again, we thank the Subcommittee for its attention to physician payment and health care quality, and we look forward to continuing to work with you in order to meet the evolving needs of our patients.

Sincerely,

Johan S. Bakken, MD, PhD, FIDSA
IDSA President

About IDSA

IDSA represents over 10,000 infectious diseases physicians and scientists devoted to patient care, disease prevention, public health, education, and research in the area of infectious diseases. Our members care for patients of all ages with serious infections, including meningitis, pneumonia, tuberculosis, HIV/AIDS, antibiotic-resistant bacterial infections such as those caused by methicillin-resistant *Staphylococcus aureus* (MRSA) vancomycin-resistant enterococci (VRE), and Gram-negative bacterial infections such as *Acinetobacter baumannii, Klebsiella pneumoni*ae, and *Pseudomonas aeruginosa*, and, finally, emerging infectious syndromes such as Ebola virus fever, enterovirus D68 infection, Zika virus disease, Middle East Respiratory Syndrome Coronavirus (MERS-CoV), and infections caused by bacteria containing the New Delhi metallo-beta-lactamase (NDM) enzyme that makes them resistant to a broad range of antibacterial drugs.

Nov. 17, 2015

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

Re: CMS-3321-NC: Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models

Dear Administrator Slavitt:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the Request for Information entitled, "Request for Information Regarding Implementation of the Merit-Based Incentive Payment System, Promotion of Alternative Payment Models, and Incentive Payments for Participation in Eligible Alternative Payment Models" released on Oct. 1, 2015 with file code CMS-3321-NC. We look forward to working with the Centers for Medicare & Medicaid Services (CMS) to develop the framework of the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs).

MGMA helps create successful medical practices that deliver the highest-quality patient care. As the leading association for medical practice administrators and executives since 1926, MGMA helps improve members' practices and produces some of the most credible and robust medical practice economic data and data solutions in the industry. Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties in which more than 280,000 physicians practice.

Introduction

In the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the sustainable growth rate formula, Congress recognized the significant regulatory burdens placed on physicians and group practices under Medicare's increasingly complex and unsustainable quality reporting programs. As such, MACRA instructed CMS to consolidate PQRS, the value-based payment modifier (VBPM), and the EHR Incentive "Meaningful Use" Program into the new MIPS. While MGMA is pleased to work with CMS to develop a harmonized MIPS program, we are concerned with the over-reliance of this RFI on the existing flawed programs. The intent behind MACRA was to hit the reset the button on these programs; yet the volume of detailed and presumptive questions raised in this RFI indicates that the agency may already be overlooking a critical opportunity to eliminate the myriad of duplicative reporting requirements. Overall, the tone of this RFI signals that CMS is looking backward instead of forward.

MGMA strongly urges CMS to fundamentally simplify how it currently measures and evaluates cost and quality rather than building MIPS upon the collapsing foundation of Meaningful Use, PQRS, and the VBPM. We view this RFI as the starting point of a much larger dialogue with physician practices. Only with an ongoing dialogue with clinical experts and physician groups will we truly be able to answer these questions.

In principle, MGMA believes that the MIPS and APM programs should meet a standard of core objectives in order to move the new payment system forward and empower groups and providers to innovate new processes of care. We worked closely with the physician community to develop consensus on a core set of principles, and we ultimately believe the framework of MIPS and APMs should:

- **Support delivery system improvements.** Constraints and limitations of current payment systems that only obstruct physician-identified care improvements must be eliminated. In addition, requirements for new models should be flexible enough to support different organizational arrangements and patient population needs so that innovation can truly flourish.
- **Avoid administrative and cost burdens for patients.** Patients should not be unduly burdened with hidden costs, administrative requirements or other obstacles that discourage them from seeking care or fulfilling treatment plans.
- **Reduce administrative burdens for physicians.** Administrative burdens must be limited and reporting tasks streamlined so that the delivery of patient-centered care is the principal focus in all clinical settings.
- **Improve current quality measurement and reporting systems.** Medicare's existing quality measurement and reporting programs cannot and should not simply be combined to form the MIPS program. These currently separate programs must be carefully assessed, revised, aligned, and streamlined into a coherent, flexible system that is truly relevant to high-value care. In particular, the regulatory framework for EHR systems under the Meaningful Use program must be revised to eliminate obstacles to technological innovation, enable interoperability and improve usability to meet the needs of patient care and reduce the burden of excessive data collection requirements on physician practices.
- **Recognize patient diversity.** Risk adjustment for patient characteristics related to health status, stage of disease, genetic factors, local demographics and socioeconomic status must be reflected in performance assessments to accommodate variations in patient need and cost of care and to ensure broad access to high-value care.
- **Provide a choice of payment models.** Physicians in all specialties, practice settings, and geographic areas should have the opportunity to choose from the payment models available, based on what best accommodates their practice and the needs of their patients.
- **Be equitable.** No specialty or payment model should put forth disproportionate resources in order to succeed, nor should any specialty experience hardship because insufficient resources have been devoted to develop quality measures or other delivery model components that are relevant to their patients and scope of care.
- **Be relevant and actionable.** Physicians should be held accountable only for the aspects of cost and quality that they can reasonably influence or control. Patient attribution methods must reflect these concerns. Timelines and deadlines must be realistic,

significant policy changes should be phased-in, and feedback on individual performance and benchmarks must be accurate, timely and actionable.

- **Provide stability and educational resources.** Payment systems must provide adequate and predictable resources, and ensure that physicians have access to tools they will need to redesign their practices to support the delivery of high-value care to all patients.
- **Be transparent.** Performance expectations and assessment methodologies must be valid, clinically relevant, scientifically tested, and transparent so that physicians have access to timely, accurate and actionable data for managing patient care. Medicare must provide claims and other performance data to physicians on the patient population covered by the delivery and payment model used in their practice.

Merit-Based Incentive Payment System (MIPS)

MIPS Identifier and Exclusions

CMS: *Should we use a MIPS eligible professional's (EP's) taxpayer identification number (TIN), national provider identifier (NPI), or a combination thereof?*

Because success in MIPS will require a concerted effort at the group practice level to develop a robust health information technology infrastructure, demonstrate clinical practice improvement, and identify and reduce potentially wasteful resource use, CMS should evaluate MIPS performance and apply a MIPS payment increase or decrease at the group practice level. MGMA believes that CMS should utilize a group practice's existing TIN as its principal MIPS identifier. MGMA is concerned that applying a MIPS payment increase or decrease at the individual level would undercut a practice's ability to manage the impact of MIPS and create a chaotic scenario in which every physician and practitioner in a group is subject to different Medicare conversion factors, which will be further complicated anytime a provider switches practices. MIPS should support and encourage the group practice model.

CMS: *Should we create a distinct MIPS identifier? What are the advantages and disadvantages associated with creating a distinct MIPS identifier?*

MGMA discourages CMS from creating a new MIPS identifier. Requiring groups and providers to familiarize themselves with and register under a new identifier in addition to navigating the changes under this new payment system would pose an unnecessary burden at a time of major transition. In addition, it is not clear that CMS would be able to administer payments or penalties sufficiently through a new identifier separate from a TIN and whether the identifier would require modifications to the 1500 claim form.

CMS: *What safeguards should be in place to ensure that MIPS EPs do not switch identifiers if they are considered "poor-performing?"*

Applying the MIPS payment adjustment at the TIN level will achieve CMS' aim of closing potential loopholes through which EPs may avoid a MIPS payment reduction by switching identifiers. Although obtaining a new unique MIPS identifier would likely be administratively burdensome and challenging, it is unlikely to be as expensive and time-intensive as dissolving an existing TIN and creating a new one, which among other things, typically requires a group to renegotiate its payer contracts. As a result, tying MIPS to a group practice's existing TIN not

only serves to eliminate unnecessary hurdles associated with establishing and obtaining a new identifier, but also reduces the likelihood that EPs will elude MIPS payment reductions by switching identifiers.

CMS: *Should a different identifier be used to reflect eligibility, participation, or performance as a group practice vs. as an individual MIPS EP? If so, should CMS use an existing identifier or create a distinct identifier?*

While CMS should evaluate MIPS performance at the group practice level and apply MIPS payment increases or reductions to providers billing under the group's TIN, the agency should permit individual practitioners or subsets of EPs in the group to report, attest, or otherwise document their quality, resource use, meaningful use of EHR, and clinical practice improvement activity data. CMS should welcome a variety of measures and reporting vehicles to ensure the agency is fully capturing a group practice's MIPS narrative, particularly for multi-specialty groups and in the event that the same measures or reporting options may not be relevant to all of the providers within the group. We emphasize that these important internal reporting decisions need to be left to the group practice and its practitioners, not handed down from CMS.

CMS: *What safeguards should be in place to ensure that we are appropriately assessing MIPS EPs and exempting only those EPs that are not eligible for MIPS?*

Under MACRA, providers who are new to Medicare, providers who participate in qualifying APMs, or providers who meet a to-be-determined low-level threshold of Medicare claims (which may be based on a minimum number of individuals enrolled, items and services furnished, or allowed charges billed) will be exempt from participating in the MIPS program. CMS needs to ensure that providers know where they fall in relation to the low-volume threshold or their approved APM status before it is too late for them to participate in MIPS. The consequences of not informing providers of their MIPS eligibility and APM qualification will result in medical groups receiving unfavorable assessments that carry heavy penalties if it is discovered at the end of a performance year that they should have participated in MIPS. This information needs to be clearly and accurately communicated to groups and providers as close to the start of a performance year as possible.

Virtual Groups

CMS: *Should there be a maximum or a minimum size for virtual groups? Should there be limitations, such as that MIPS EPs electing a virtual group must be located within a specific 50-mile radius or within close proximity of each other and be part of the same specialty? Should there be a limit placed on the number of virtual group elections that can be made for a particular performance period for a year as this provision is rolled out? Should we limit for virtual groups the mechanisms by which data can be reported under the quality performance category to specific methods such as a qualified clinical data registry or utilizing the group's web interface?*

The complexities and potential consequences of this largely untested and undefined mechanism cannot be identified through the technicalities raised in this RFI. In general, MGMA urges CMS to consider the flexibility afforded by MACRA under Section 1848(q)(5)(I)(ii), in which a virtual group **may** be based on appropriate classifications of providers, such as by specialty designations or geographic areas. However, as CMS works to implement the virtual group option, MGMA

strongly encourages the agency to first work with the provider community to establish a framework for the virtual group option. Imposing limits on size, reporting mechanism, specialty designation, geography, or eligible participants who may convene a virtual group is not the same as defining this reporting option. In addition, the lack of framework raises the risk of potential compliance and anti-trust issues.

CMS also needs to inform the provider community of the specific issues the agency faces in implementing this option. We encourage the agency to take a more active role in this dialogue so that stakeholders can work with CMS to mold the virtual group option into a viable reporting method.

Quality Performance Category: Reporting Mechanisms Available for Quality Performance

CMS: *Should we maintain all PQRS reporting mechanisms noted above under MIPS?*

CMS needs to take advantage of the opportunity to fix what is not working in the current quality reporting programs. At the same time, the initial transition to MIPS needs to be as seamless and non-disruptive to clinical practice as possible. At a minimum, CMS should maintain all of the current PQRS reporting mechanisms to ensure flexibility for providers and groups that have different resource capabilities, and to provide continuity as practices transition to MIPS.

CMS: *Should we maintain the same or similar reporting criteria under MIPS as under the PQRS? What is the appropriate number of measures on which a MIPS EP's performance should be based? Should we maintain the policy that measures cover a specified number of National Quality Strategy (NQS) domains?*

MGMA strongly advises CMS to eliminate the reporting burdens that exist under PQRS when establishing the MIPS quality performance category. Under the current PQRS program, providers and groups must report nine measures across three NQS domains. Continuing to require that groups complete 100% of the work that is currently needed to be successful in PQRS under the MIPS program where quality measures will only account for 30% of the composite score will essentially triple the administrative burden and continue the tradition of reporting for reporting's sake. Furthermore, CMS does not have adequate evidence to justify maintaining the current level of required measures. There is no sound reason to continue these requirements under MIPS when it has been clear that many groups and providers struggle to meet current program requirements.

Instead, CMS should reduce the reporting requirement to the standard of three measures and allow EPs and group practices to report additional quality measures at their discretion. Additionally, requiring a base level of NQS domains to be reported presents an unnecessary challenge for groups and EPs, particularly specialty providers, to find enough relevant clinical quality measures that also fit into an artificially-constructed domain.

CMS: *Should we require that certain types of measures be reported? For example, should a minimum number of measures be outcomes-based?*

Providers and groups should have maximum flexibility to choose measures. MGMA opposes a minimum threshold for outcomes measures, as we are concerned that it may preclude some specialties from meeting program requirements due to small sample sizes and difficulty demonstrating how providers contributed to a required outcome. In addition, existing patient attribution and risk adjustment methodologies remain unreliable, which unfairly prevents groups and providers from demonstrating genuine clinical successes.

CMS should consult with physician specialties to determine which providers are able to report certain types of measures, including potentially evidence-based process measures that demonstrably lead to improved outcomes. In cases where there are no applicable measures, physician specialties can work with CMS to determine alternative measure options.

CMS: *What are the potential barriers to successfully meeting the MIPS quality performance category?*

First and foremost, CMS should reduce administrative complexities in reporting quality data, particularly reporting through multiple portals, undiscernible feedback reports, the uncertainty of who is eligible to report and for how many patients, and the challenges in finding clinically-relevant quality measures that also fit into artificially constructed quality domains. These complexities are overwhelming, discourage EPs from reporting, and ultimately detract from patient care. MIPS should not carry on the tradition of flawed quality and cost assessments under a different name. We remind CMS that the intent behind creating MIPS is to hit the reset button and put an end to the broken elements of current quality programs in order to create a truly consolidated and workable program.

In addition, CMS must continue to address measurement gaps and improve the existing set of measures. MGMA is concerned that CMS has not yet allocated MACRA-authorized funding toward this effort, and we urge the agency to do so as expeditiously as possible considering the first MIPS performance year may begin in 2017. Congress allocated funding because it is widely recognized that the current lack of clinically relevant and statistically valid quality measures is a significant hindrance to quality improvement efforts and will remain one of the greatest barriers to success in the MIPS program if unaddressed. We urge CMS to immediately fund measure development in order to close the gap in available measures for certain specialties and conditions, to work with the appropriate bodies to identify insufficiencies in the current measure list, and fill the identified gaps in an ongoing, transparent manner.

Data Accuracy

CMS: *What should CMS require in terms of testing the qualified registry, qualified clinical data registry, or direct EHR product, or EHR data submission vendor product? How can data be enhanced to improve data integrity?*

MGMA agrees that data accuracy should be the foundation of any quality reporting program. Ensuring that data inaccuracies are avoided from the outset will ensure the MIPS program begins on the right foot. However, MACRA does not explicitly outline any new data integrity requirements for MIPS; thus, when addressing this data accuracy concern, we encourage CMS to

balance the need for data integrity standards with sensible policies that foster physician trust in the system while eliminating undue administrative burdens. We encourage CMS to work with vendors, specialty societies, registries, and other stakeholders to strengthen data submission standards and safeguard against passing costs or burdens to practices.

CMS: *If CMS determines that the MIPS EP (participating as an individual EP or as part of a group practice or virtual group) has used a reporting mechanism that does not meet our data integrity standards, how should CMS assess the MIPS EP when calculating their quality performance category performance score? What consequences should there be for MIPS EPs?*

Given the recently discovered 2014 PQRS data submission inaccuracies submitted by Qualified Clinical Data Registries (QCDRs) and EHRs, it is clear that CMS has not adequately ensured that data integrity standards exist in the current quality reporting programs. The application and vetting season for qualified entities presented an opportunity to identify weaknesses in data integrity standards and for vendors to communicate any challenges in meeting data submission format requirements. Instead, as the errors were not discovered until late 2015, CMS has announced that it will classify all affected groups and providers as having provided "average quality, average cost" healthcare for the 2016 payment year. Unfortunately, groups and EPs that provided high quality care at lower costs will miss the opportunity to earn an upward adjustment as a result of subpar vendor data integrity standards, even though these issues were not under practices' control.

Under the MIPS program, more groups and EPs will likely choose to report via a QCDR or EHR, as MACRA encourages groups and providers to utilize them. Therefore, we urge the agency to be proactive and not reactive in communicating submission problems to both vendors and practices during a performance year, and allow medical groups and providers the opportunity to resubmit and correct data within a reasonable timeframe in the case of any submission problems. CMS's policy of holding groups harmless from penalties and considering them to have provided "average quality, average cost" healthcare should be a secondary policy, not the first and only option. Vendors should also be forthright if they are unable to meet data submission standards so that groups and providers can find an alternative means to report MIPS data. We urge CMS to find solutions to keep medical practices from being held accountable for vendors' mistakes.

Use of Certified EHR Technology (CEHRT) under the Quality Performance Category

CMS: *Under the MIPS, what should constitute use of CEHRT for purposes of reporting quality data? Instead of requiring that the EHR be utilized to transmit the data, should it be sufficient to use the EHR to capture and/or calculate the quality data? What standards should apply for data capture and transmission?*

Using any effective method of electronic capture and transmission of quality data should satisfy the requirement that an EP employ an "interoperable" system. In particular, CMS should not require that CEHRT use the HL7 Quality Reporting Document Architecture (QRDA) for capturing and transmitting data. Further, transmission of quality data using XML should be permitted. Requiring CEHRT and QCDRs to only use QRDA will require significant time and

resources for vendors to deploy and physician practices to implement. Thus it is imperative that sufficient time be provided for the industry to adopt this approach.

MGMA contends that there should be a base-level standard required by all health IT systems (including QCDRs) for submitting or accepting CQM data. Both QCDR XML and QRDA category III standards are currently permitted for PQRS reporting. However, for those EPs participating in both PQRS and Meaningful Use, only the QRDA format is accepted by CMS for reporting. While both QCDR and QRDA formats are represented in XML, 2015 Edition Certification requires that all health IT modules used for the submission of CQM data must be certified to the QRDA (I & III) format. As QRDA is already required for Meaningful Use and PQRS reporting, and 2015 Edition Certification also requires QRDA I & III, we believe the industry is best served at this point by identifying QRDA as the reporting standard. However, we urge the Administration to work with industry stakeholders to develop a glide path to migrate health IT products over to a more flexible data reporting format in the future.

Finally, MGMA recommends that medical groups receive credit for the MIPS Meaningful Use option when reporting quality measures electronically to CMS through either registry or EHR reporting. In addition, any approved quality measure reported using this approach should count for full Meaningful Use credit, not merely the electronic clinical quality measure component, as is currently the case.

Resource Use Performance Category

CMS: *Currently under the VBPM, we use the following cost measures: 1) total per capita costs for all attributed beneficiaries measures, total per capita costs for beneficiaries with specific conditions (diabetes, coronary artery disease, chronic obstructive pulmonary disease, heart failure), and Medicare spending per beneficiary. What role should episode-based costs play in calculating resource use and/or providing feedback reports to MIPS EPs under Section 1848(q)(12) of the Act?*

Under this RFI, CMS implies its intention to essentially continue and expand the VBPM's current cost measures under MIPS. MGMA vehemently opposes this approach. Current VBPM measures are irrelevant for many physicians, either because they have no patients attributed to them, or because they have little opportunity to influence costs. CMS needs to conduct rigorous data analysis to replace the flawed VBPM methodology with improved episode-based measures, attribution policies that accurately illustrate the patient-provider relationship, and risk adjustment methodologies that do not penalize or discourage providers from treating atypical or chronically-ill populations. The agency should only consider adopting measures that have a solid evidence base and are developed through a multi-specialty, clinician-led process. Transparency and physician involvement in developing these measures and accompanying methodologies are especially critical.

CMS: *How should we apply the resource use category to MIPS EPs for whom there may not be applicable resource use categories?*

CMS should consult with the specialties whose providers are most likely to experience this shortage in order to determine how best to redistribute the available points in this category. There may be an opportunity to redistribute weight to other MIPS categories or create alternative measures for providers who have no applicable measures in this category.

Clinical Practice Improvement Activities

CMS must define clinical practice improvement activities in the broadest terms possible. This category should not be created as another mechanism that prioritizes reporting over patient care. Rather, medical groups and providers must be given the discretion to participate in activities that best suit their unique practice and specialty needs. Many medical groups already engage in a number of activities that promote and improve the quality and efficiency of care that would be considered subcategories within the clinical practice improvement category. We encourage CMS to work with the provider community to structure this category as a feasible instrument of practice improvement efforts with appropriate flexibility to capture, not hamper, these ongoing efforts.

CMS: *Should EPs be required to attest directly to CMS through a registration system, web portal, or other means that they have met the required activities and to specify which activities on the list they have met? Or alternatively, should qualified registries, QCDRs, EHRs, or other health IT systems be able to transmit results of the activities to CMS? How often should providers report or attest that they have met the required activities?*

Physicians should have the opportunity to demonstrate their performance on clinical practice improvement activities through as simple and flexible a process as possible and through a variety of available mechanisms that best fit the group's unique capabilities. Transmission of clinical practice improvement activities should be permitted but not required through electronic health records and QCDRs when and where capabilities exist, but this should not be a requirement for success. We believe that, at the outset, no more than annual attestation may be the best option. We encourage CMS to employ the least burdensome methodology as it further develops this performance category.

CMS: *What threshold or quantity of activities should be established under the clinical practice improvement activities performance category? Should the threshold or quantity of activities increase over time?*

Clinical practice improvement activities should be based on either completion or ongoing participation in a specified activity or number of activities rather than hours devoted. Group practices and providers, not CMS, should determine what clinical practice improvement activities to report and how these are quantified. Significant stakeholder involvement is needed to define eligible activities within a widely-understood framework of this category. CMS should involve stakeholders in this process before attempting to define this category based on reporting requirements.

CMS: *How should we define the subcategory of participation in an APM?*

The definition of the APM subcategory under MIPS should not be limited to qualified APMs as defined under MACRA, but should incorporate participation in any APM including those sponsored by a commercial payer, state government agency, or Medicaid. MGMA believes that group practices that participate in an APM should receive full credit for the clinical practice improvement category.

CMS: *For the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS reporting option specifically, should this still be considered as part of the quality performance category or as part of the clinical practice improvement activities category? What considerations should be made as we further implement CAHPS for all practice sizes?*

CMS should allow the CAHPS for PQRS survey to be optional under the clinical practice improvement activity category. We do not believe that patient experience and patient satisfaction should be considered quality metrics, as factors included in surveys are often outside a physician's control. Patient satisfaction is important; however, it does not always translate to better clinical outcomes.

Meaningful Use of Certified EHR Technology (CEHRT) Performance Category

Meaningful Use has already been named as one of the four components of MIPS. That said, by sunsetting the current Meaningful Use Program, Congress has signaled that it wants the Administration to reformulate the program prior to its inclusion in MIPS. While Stage 1 of Meaningful Use accelerated adoption of EHR technology (with now approximately 75% of clinicians using EHRs compared to just 18% prior to the start of the program), Stage 2 has proven exceedingly difficult for EPs to meet with just 12% of EPs to date having attested to meeting the more rigorous Stage 2 requirements. Rather than move ahead with an ill-conceived third stage, we strongly urge CMS to hit pause on the program and seriously reevaluate and redesign the Meaningful Use component of MIPS for 2019.

MGMA and numerous other stakeholders have urged the Administration to take a different path to achieving the vision originally laid out by Congress in the American Recovery and Reinvestment Act. The program should focus on promoting interoperability and allowing innovation to flourish as vendors respond to the demands of physicians and hospitals, rather than the current system where vendors channel all of their energy toward meeting ill-informed check-the-box requirements. Despite all this, the Administration recently issued misguided Stage 3 requirements that only perpetuate failings of the current program.

With the premature release of the Stage 3 final rule, we are concerned that CMS has imposed a regulation that will lead to widespread EP failure. Rather than build on the modest improvements made to Stage 2, the agency has reverted back to the same fundamental flaws in the previous stage of the program by focusing heavily on increased measure thresholds and excessive documentation. The focus needs to be on what clinicians really need, improving interoperability and usability. CMS will only guarantee continued failure should Stage 3, as it is currently written, be incorporated into MIPS.

It is absolutely critical that the MIPS Meaningful Use component be crafted in such a way that encourages clinicians, especially specialty physicians and those practicing in smaller and rural settings, to adopt these important technologies and meet program requirements, and does not inhibit them from doing so with unachievable measures and thresholds. With a significant percentage of private practice EPs still not participating in the EHR Incentive Program, we remain concerned that simply requiring the current Stage 3 requirements for MIPS will actively discourage clinicians from acquiring and using EHR technology in a "meaningful" way.

MGMA general recommendations on the Meaningful Use Program

As the Meaningful Use component of MIPS is developed, we urge the Administration to consider the following general principles:

- Apply Meaningful Use at the TIN or group practice level.
- Assess all measures to determine:
    - Relevance to all specialties and the conditions they treat;
    - Cost-benefit implications, including the cost of lost clinician productivity; and
    - Whether actions are controlled by the physician and not by patients, technology, or other factors over which providers have little or no influence.
- Ensure that measure thresholds are reasonable and achievable.
- Establish reporting periods of 90 or fewer consecutive days.
- Avoid requiring actions of patients or third parties to meet program requirements.
- Focus on achieving interoperability.
- Encourage improvements in software usability.
- Work directly with physician specialty societies and other key stakeholders to develop appropriate measures and thresholds.

CMS: *Should the performance score for this category be based solely on full achievement of Meaningful Use? For example, an EP might receive full credit (for example, 100 percent of the allotted 25 percentage points of the composite performance score) under this performance category for meeting or exceeding the thresholds of all Meaningful Use objectives and measures; however, failing to meet or exceed all objectives and measures would result in the EP receiving no credit (for example, zero percent of the allotted 25 percentage points of the composite performance score) for this performance category. We seek comment on this approach to scoring.*

To date, Meaningful Use has been developed in such a way that an EP can fail one minor component, and consequently fail the entire program for that reporting year, missing out on an incentive payment and falling subject to penalties. With MIPS, CMS has the opportunity to redesign Meaningful Use to permit a more flexible approach for group practices. We contend that the current "all or nothing" method be replaced with a scalable approach that would provide a practice a score for partially meeting the requirements. Should a group practice fail to satisfy an individual measure, and not meet the prerequisites of any available exclusion from the failed measure, it should only lose a smaller, proportional percentage—not the full 25%. Similarly, each measure requirement itself should have a tiered approach to avoid having providers score a

zero on a measure when they could have been 99% successful in meeting a threshold (i.e., electronic prescribing).

CMS: *Should CMS use a tiered methodology for determining levels of achievement in this performance category that would allow EPs to receive a higher or lower score based on their performance relative to the thresholds established in the Medicare EHR Incentive Program's Meaningful Use objectives and measures? For example, an EP who scores significantly higher than the threshold and higher than their peer group might receive a higher score than the median performer. How should such a methodology be developed? Should scoring in this category be based on an EP's under- or over-performance relative to the required thresholds of the objectives and measures, or should the scoring methodology of this category be based on an EP's performance relative to the performance of his or her peers?*

In general, medical groups should be given considerable flexibility when participating in these programs. MGMA recommends that performance tiers be utilized only for research and educational purposes, not for MIPS scoring. Due to significant variability between medical specialties, practices should not be judged on an arbitrary performance benchmark unless that benchmark is appropriately specialty and subspecialty-specific risk-adjusted. Is the practice in an area where fewer pharmacies accept e-prescriptions? Are physicians treating patient populations that have less access to the Internet? These factors and others could significantly impact a practice's ability to score higher on a measure scale relative to their peers. Using a performance-based/tiered methodology for the Meaningful Use component of the composite score could unfairly penalize medical groups based on circumstances largely outside their control—such as subspecialty/scope of practice, location/setting, health information exchange network availability, business environment/competition, and patient population, among others.

CMS: *How should hardship exemptions be treated?*

Group practices that successfully apply for a hardship exception should receive the full 25% score allotted to this category. MGMA also supports a MIPS hardship exception category for practices that have switched from one CEHRT product to another or who have had their CEHRT decertified. As it is a costly and time-consuming process to move from one EHR product to another, we recommend the exception apply for a minimum of three years.

Concerning the lack of available internet access exception, we recommend CMS publish a definitive explanation of what constitutes "limited access" and provide links to a list of all counties that have been identified by the Federal Communications Commission or another agency as having limited internet access. MGMA also supports expanded hardship exceptions for practices that experience unforeseen circumstances that make it impossible to demonstrate Meaningful Use requirements through no fault of their own and encourage expanding this exception to five years after they begin experiencing said unforeseen circumstances.

While we appreciate that a number of medical specialties (Anesthesiology, Radiology, and Pathology) have been granted an exception due to the fact that they typically do not have face-to-face encounters with patients, we do not believe these exemptions should be time-limited. We contend that should a practice qualify for this "specialty exception," it is because they do not

have the ability to participate in Meaningful Use based on current specialty-specific technological capabilities and program requirements, which will not change over time.

In addition, we recommend that once a hardship application has been submitted, applicants receive an immediate email receipt confirmation. This would avoid the situation that some of our members have encountered, where they find out after the hardship exception deadline has passed that the application was not officially received. Similarly, we recommend that an applicant receive an email confirmation of acceptance or denial of the hardship exception as soon as it becomes available.

Finally, hardship "exclusions" should also be considered. This would replicate what CMS established in FAQ 12775, where the agency permitted an EP to apply for an alternate exclusion for public health reporting. This "exclusion" approach is not in lieu of exceptions, but rather should be offered to practices that experience challenges (typically software-related) in meeting one or more of the program requirements so that they are still able to participate in the program as a whole.

Development of Performance Standards

CMS: *Which specific historical standards should be used?*

Although MACRA requires CMS to **consider** historical performance standards, it stops short of requiring the agency to actually **use** historical standards. Given the imperfect and still-changing nature of the current programs, it is preferable to use some future year as the basis for determining what constitutes "historical" performance. The legislative intent is not to base this future program on current, flawed program standards, since a large percentage of physicians will have VBPM scores that are not based on actual data and others will have scores that bear little relevance to their own performance. Consequently, the VBPM would serve as an ill-conceived foundation for performance under MIPS. CMS should consult with medical organizations to identify potential sources of data, including QCDRs, for alternative historical performance standards.

CMS: *How should we define improvement and the opportunity for continued improvement? How should CMS incorporate improvement in the scoring system or design an improvement formula? What should be the threshold(s) for measuring improvement?*

MIPS is not designed to be a tournament-style program, as CMS is required to disclose benchmarks prior to the start of a performance period. Abundant education and outreach regarding performance standards and scoring is paramount to success of the program, so that groups and providers know exactly what standards they are expected to achieve.

Improvement may be defined on a yearly basis; however, CMS should not introduce methodologies that are untested or at least not without significant education to ensure providers trust in the scoring system.

CMS: *Should CMS use the same approach for assessing improvement as is used for the Hospital Value-Based Purchasing Program? What are the advantages and disadvantages of this approach?*

The Hospital Value-Based Purchasing Program awards participants with points for improvement compared to an established baseline and additional points for achievement as compared to performance from the prior year. This may work in the hospital environment; however, there are thousands of group practices operating in a fluid environment of recruitment, acquisition, expansion, and reduction. The current two-year gap between performance and payment years makes it extremely difficult to gauge improvement.

Feedback Reports

CMS: *What types of information should we provide to EPs about their practice's performance within the feedback report? For example, what level of detail on performance within the performance categories will be beneficial to practices?*

CMS must be forthcoming in feedback reports regarding the methodologies used to comprise benchmarks or attribute patients for a particular measure. This information must be clearly identified and easy to interpret. Current feedback reports lack key details that are necessary to understand the methodologies used to arrive at benchmarks and other calculations. This creates frustration and distrust among practices about the nature of how these determinations are made, and must be avoided going forward if CMS wants to create a program grounded in legitimacy and transparency.

Where appropriate, CMS should aim to display feedback and performance measurement information graphically with additional details displayed elsewhere. CMS should bear in mind that the purpose of these reports is to allow practices to estimate their current performance and to demonstrate potential areas of improvement. The agency should design these reports accordingly with specific, actionable information. Detailed information should be provided in feedback reports, including the ability to see practice-level, high-level, overall performance information, and drill-down information on physicians as associated with individual patient information.

CMS: *What other mechanisms should be leveraged to make feedback reports available? Currently, CMS provides feedback reports for the PQRS, VBPM, and the Physician Feedback Program through a web-based portal. Should CMS continue to make feedback reports available through this portal?*

With technology constantly changing, it is critical that CMS take an ongoing approach to improving the way performance information is disseminated to physicians and practices. Stakeholder input should be solicited throughout this process to ensure that feedback is provided in a format that works best for physicians and is meaningful to their practice's ongoing improvement activities. These reports should also be provided in a variety of mediums, including but not limited to web-based reports, as well as dashboards and paper reports.

CMS: *Who within the EP's practice should be able to access the reports?*

To improve overall efficiency and actionability, feedback reports should be accessible to physicians, practice administrators or other individuals delegated by the physician. It is important for physician group practices to have access to overall organization performance feedback in order to drive quality improvement.

The log-in process for accessing reports must be simple and user-friendly. There have been ongoing problems with accessing reports due to the overly complicated log-in process and cumbersome password requirements which reset at very short intervals, and ultimately limit access to these reports. CMS staff, not just contractor staff, should also be more accessible to help physicians and administrators access and interpret these reports.

CMS: *With what frequency is it beneficial for an EP to receive feedback?*

CMS must provide ongoing, real-time feedback on performance and should regularly consult with stakeholder groups to determine the best presentation and format for sharing performance feedback information with physicians and practices. In addition, effective education does not include sending the same resources multiple times per day or week. MGMA has consistently asked CMS to prioritize its education and outreach efforts and develop more timely resources that educate providers and practice staff to help them to understand feedback well enough to translate the information into meaningful improvements in their practices.

Alternative Payment Models

Payment Incentive for APM Participation

CMS: *How should CMS define 'services furnished under this part through an eligible APM (EAPM) entity'? What policies should the Secretary consider for calculating incentive payments for APM participation when the prior period payments were made to an EAPM entity rather than directly to a qualifying participant (QP), for example, if payments were made to a physician group practice or an ACO? What are the effects of those policies on different types of EPs (that is, those in physician-focused APMs versus hospital-focused APMs, etc.)?*

MACRA stipulates that, for 2019 through 2020, providers may be considered either a partial QP or a QP for purposes of determining participation in an eligible APM. This distinction is determined through a threshold that is based on a certain percentage of Medicare Part B payments for covered professional services that are furnished through an eligible APM in the most recent reporting period. In 2021, this threshold may consider a combination of all-payer and Medicare revenues for purposes of making this determination, which will establish how many participants will receive the lump sum 5% incentive payment.

In order to define "services furnished under this part through an EAPM entity," MGMA recommends that CMS consider that APMs will vary immensely in structure. Consequently, this definition will require as much flexibility as possible to account for different organizational

governance structures, the level of physician leadership in the entity, and the manner in which it is paid (fee-for-service, population-based payments, or capitation). MGMA believes that CMS has an opportunity during the application process to require the APM to establish how revenues will be distributed to providers in the APM. For instance, an APM that only looks at revenues for physician and professional services will use a different method for determining revenue thresholds than another APM that counts both revenues for hospital and post-acute care services. For these reasons, defining these thresholds should be malleable and determinable by the APM in its application process, and discussed in partnership with CMS so innovation is not stifled.

Nominal Financial Risk

CMS: *What is the appropriate type or types of "financial risk" under section 1833(z)(3)(DD)(ii)(1) of the Act to be considered an EAPM entity? What is the appropriate level of financial risk "in excess of a nominal amount" under Section 1833(z)(3)(D)(ii)(1) of the Act to be considered an EAPM entity?*

The definition of "more than nominal financial risk" should not be based on the relative gain or loss to the Medicare Trust Fund, but on how much the physician practice or the APM entity itself gains or loses. "More than nominal financial risk" should be defined to allow for physicians to take accountability for services they can truly influence and not for aggregate Medicare spending. The financial risks associated with creating and operating an APM can be staggering, considering that in many cases, organizations do not see a return on their investments for several years, if at all. Start-up costs for ACOs, specified by MACRA as a current example of an APM, often top $4 million, according to a 2013 study by the National Association of Accountable Care Organizations. APMs will require operating capital to finance data analysis for care coordination strategy development, investments in health information technology, ongoing costs for care managers and personnel.

Quality Measures

CMS: *What criteria could be considered when determining "comparability to MIPS" of quality measures used to identify an EAPM?*

CMS should make every effort to harmonize measures across all programs, including MIPS and APMs. At the same time, CMS should not tie the hands of an APM by defining it through the lens of MIPS, which is intended to be a separate program for this very reason. MGMA recommends that the APM utilize a set of quality measures that align with the overall goal of the organization. We underscore the importance for clinical equivalence in establishing this definition of 'comparability.' There should be a minimum clinical standard across all CMS programs, including MIPS and APMs. However, providers participating in an APM should have a significant opportunity to decide and potentially develop new measures that grant them the flexibility to most accurately represent the goal and design of the APM while still demonstrating quality performance.

Use of Certified EHR Technology

CMS: *What components of certified EHR technology as defined in section 1848(o)(4) of the Act should APM participants be required to use? Should APM participants be required to use the same certified EHR technology currently required for the Medicare and Medicaid EHR Incentive Programs or should CMS other consider requirements around certified health IT capabilities?*

While the certification process established by the Office of the National Coordinator for Health Information Technology (ONC) and performed by Authorized Certification Bodies (ACBs) has been successful to a point in establishing that certified software products meet a minimum set of requirements to count towards EHR participation in the Meaningful Use Program, it has failed in a number of critical areas. First, and most importantly, there is no requirement that the software actually improve the clinician's ability to provide high-quality patient care. Inadequate EHR design is a roadblock to direct interaction with patients as clinicians are now forced to expend additional time documenting information required by Meaningful Use.

Clinicians report that features such as pop-up clinical decision support reminders, awkward menus and shoddy user interfaces are hindering performance. We urge the government to drive development of EHRs that augment and enhance the clinician-patient encounter. EHRs should also be designed to better facilitate electronic patient engagement. Often, the patient engagement component of the EHR, a critical component of Meaningful Use, does not meet the needs of either the clinician or the patient. Expensive, cumbersome to sign up for and navigate, and security-challenged, portals have a ways to go before they are seamlessly integrated into practice workflow. Incorporating increased interoperability between EHR systems and patients' mobile technologies and telehealth technologies, through a modified certification process, would be a pathway to improving patient engagement.

CMS: *How should CMS define "use" of certified EHR technology as defined in section 1848(o)(4) of the Act by participants in an APM? For example, should the APM require participants to report quality measures to all payers using certified EHR technology or only payers who require EHR reported measures? Should all professionals in the APM in which an eligible alternative payment entity participates be required to use certified EHR technology or a particular subset?*

We agree that APMs should require a baseline set of technology functionality bearing in mind that technology should support the APM, not define it. Current certification requirements significantly limit the utility of CEHRT to APMs by requiring expensive functionalities that are often irrelevant to the APM. We urge the government to establish a set of more appropriate baseline functionalities which should be developed with input from the physician community and then communicated to potential APM participants. Adoption of these functions could be incorporated as a component of the APM application process. This approach would ensure that practices implements a baseline standard of technological functionalities with the ability to customize additional capabilities that are more in sync with the specific needs of that APM. Importantly, this would not require APMs to purchase prohibitively expensive software that add no additional benefits for the APM and only serve to act as a disincentive to APM participation.

CMS: *What are the core health IT functions that providers need to manage patient populations, coordinate care, engage patients and monitor and report quality? Would certification of*

additional functions or interoperability requirements in health IT products (for example, referral management or population health management functions) help providers succeed within APMs?

Few of the current certification requirements facilitate effective management of patient populations, assist in referral management or effectively support coordination of patient care. Replacing a formal and costly certification process with an APM technology attestation model would have a number of benefits. For example, the APM-related certification cost would be eliminated for vendors, resulting in decreased software costs for practices. Most importantly, vendors could concentrate attention on innovating software and improving the usability of their products, including customizing systems to fit an APM's unique set of needs.

Physician-Focused Payment Models

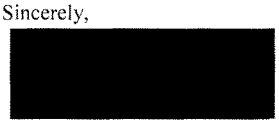
CMS: *How should physician-focused payment models be defined?*

Physician-focused payment models should allow physicians to earn incentive payments intended for qualifying APMs without having to meet the criteria established under MACRA to be considered an eligible APM. It is critical that CMS establish transparent criteria and a clear pathway for models to be proposed to the PTAC and for those models that are ultimately recommended by the PTAC to HHS to be implemented by CMS as qualified APMs. CMS and the PTAC should work collaboratively with medical societies and other organizations to develop criteria, provide feedback on drafts, and provide data up-front to help in modeling impacts. Physician-focused payment models should support innovative approaches that give physicians the flexibility to deliver a more unique set of services than the restrictive requirements that payment systems currently allow. Administrative requirements should also be kept to a minimum, so that resources are spent helping patients, not covering increased administrative costs.

Conclusion

We appreciate the opportunity to offer our perspectives on implementation of the MIPS and APM programs. Should you have any questions, please contact Anders Gilberg at agilberg@mgma.org or 202-293-3450.

Sincerely,



Halee Fischer-Wright, MD, MMM, FAAP, CMPE
President and CEO

Statement of the Medical Group Management Association before the Committee on Energy and Commerce Subcommittee on Health

April 18, 2016

The Medical Group Management Association (MGMA) applauds the Committee on Energy and Commerce Subcommittee on Health (Subcommittee) for continuing to show leadership on the implementation of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

MGMA supported MACRA and the repeal of the failed sustainable growth rate (SGR) formula, which enabled group practices to begin to innovate and participate in new Medicare delivery models. With the passage of MACRA, Congress recognized the significant regulatory burdens placed on physicians and group practices under Medicare's increasingly complex quality reporting programs, which were consolidated into the new Merit-Based Incentive Payment System (MIPS). In addition, MACRA supports participation in alternative payment models (APMs), which have the potential to reduce waste in the Medicare system while improving patient outcomes. This is a critical juncture in MACRA implementation. Despite our optimism with the prospect of creating a new payment system without the SGR, there is growing concern in the physician community that the Centers for Medicare & Medicaid (CMS) may be straying from Congress' intent in MACRA to simplify the reporting burdens on physician groups while rewarding the move from fee-for-service to value-based payment and delivery models. MGMA is pleased to have the opportunity to offer this statement and continue to work with the Committee, Congress, and the Administration to ensure the successful implementation of MACRA.

MGMA helps create successful medical practices that deliver the highest-quality patient care. As the leading association for medical practice administrators and executives since 1926, MGMA helps improve members' practices and produces some of the most credible and robust medical practice economic data and data solutions in the industry. Through its national membership and 50 state affiliates, MGMA represents more than 33,000 medical practice administrators and executives in practices of all sizes, types, structures and specialties in which more than 280,000 physicians practice.

In principle, MGMA believes the MIPS and APM programs should meet a standard of core objectives in order to move the new payment system forward and empower groups and providers to innovate new processes of care. MGMA worked closely with the

physician community to develop consensus on a core set of principles, and ultimately believes the framework of MIPS and APMs should:

- **Support delivery system improvements.** Constraints and limitations of current payment systems that only obstruct physician-identified care improvements must be eliminated. In addition, requirements for new models should be flexible enough to support different organizational arrangements and patient population needs so that innovation can truly flourish.
- **Reduce administrative burdens for physician practices.** Administrative burdens must be limited and reporting tasks streamlined so the delivery of patient-centered care is the principal focus in all clinical settings.
- **Improve current quality measurement and reporting systems.** Medicare's existing quality measurement and reporting programs cannot and should not simply be combined to form the MIPS program. These currently separate programs must be carefully assessed, revised, aligned, and streamlined into a coherent, flexible system that is truly relevant to high-value care. In particular, the regulatory framework for EHR systems under the Meaningful Use program must be revised to eliminate obstacles to technological innovation, enable interoperability and improve usability to meet the needs of patient care and reduce the burden of excessive data collection requirements on physician practices.
- **Provide a choice of payment models.** Physicians in all specialties, practice settings, and geographic areas should have the opportunity to choose from the payment models available, based on what best accommodates their practice and the needs of their patients.
- **Be relevant and actionable.** Physicians should be held accountable only for the aspects of cost and quality that they can reasonably influence or control. Patient attribution methods must reflect these concerns. Timelines and deadlines must be realistic, significant policy changes should be phased-in, and feedback on individual performance and benchmarks must be accurate, timely and actionable.
- **Be transparent.** Performance expectations and assessment methodologies must be valid, clinically relevant, scientifically tested, and transparent so physicians have access to timely, accurate and actionable data for managing patient care. Medicare must provide claims and other performance data to physicians on the patient population covered by the delivery and payment model used in their practice.

MGMA Efforts to Support MACRA Implementation

MACRA represents a significant legislative and policy achievement and MGMA is working to educate physician group practice leaders about the potential benefits of the law, such as up-front payments to make the necessary investments to move to a qualifying APM. Last month, MGMA and the American Medical Association partnered to

offer the Collaborate in Practice Conference, an event focusing on how practice administrators and physicians can join together to effectively lead the transition to a patient-centric, value-based environment while avoiding undue burden on physician practices. One of the highlights of the Conference was a detailed panel discussion on MACRA, emerging payment models, and the impact on the future of medicine.

MGMA created a resource center on MACRA where group practices can access information on implementation, including an hour-long webinar. Additionally, MGMA created an easy-to-digest slide deck and accompanying presenter notes that medical practice leaders can use to educate their physicians and staff on the MACRA basics, what we know about MIPS and APMs, and action steps to take today in order to prepare for the new Medicare payment model. MGMA staff travel across the country and update medical practice executives on key federal regulatory and legislative issues, including what we know about MACRA and what remains unknown as we await the proposed rule. MGMA staff also speak on a regular basis with medical group practices about what changes are on the horizon and how they can position their practices for success.

In addition to these educational and outreach initiatives, MGMA is actively engaged in multiple industry stakeholder work groups to develop consensus principles to assist CMS and the Administration in implementing MACRA in a manner that supports physician group practices as they transform their payment and delivery approaches from fee-for-service toward value-based models.

MGMA's Concerns

Among the physician community, however, there is growing concern that CMS is straying from congressional intent and developing regulations behind closed doors with limited input from stakeholders. For example, physicians and physician specialty organizations were not adequately consulted for their clinical expertise by the developers of the CMS episode groups. The episode groups are expected to play a vital role in measuring practices' efficient use of resources in both the MIPS and APM tracks. While MGMA is willing to participate in a productive dialogue with CMS about the significant reforms underway, many of our conversations to date have been one-sided. Moving forward, CMS should fulfill MACRA's instruction that the agency work closely with physician organizations, not only to ensure the clinical relevance of the new Medicare payment tracks, but also to foster physician trust and buy-in for the program.

MGMA is also concerned about the mixed messages received from the Centers for Medicare & Medicaid Innovation (CMMI). Last week, CMMI announced it was expanding the Comprehensive Primary Care Initiative (CPCI) through the Comprehensive Primary Care Plus (CPC+), set to begin in January 2017. CMMI

designates CPC+ as an alternative payment model that rewards value and quality through an innovative payment structure to support comprehensive primary care. Two days after the CPC+ announcement, it was announced that CPCI has not yet generated savings in Medicare that are sufficient to cover care-management fees and the data show only modest improvements in quality metrics. The fact that these programs are not achieving the government's stated intention of saving the Medicare program money and improving patient outcomes creates uncertainty about the longevity of these initiatives and raises doubt for physician group practices that may otherwise invest time and resources in participating in new payment models.

Similarly, the Medicare Shared Savings Program (MSSP) accountable care organization (ACOs)s have not yet produced savings for the Medicare program, and the majority of MSSP ACOs have either missed their own savings targets or failed to reach the necessary benchmark to earn a cut of the program savings. While CMS continues to tweak the program and most recently adopted a long-time recommendation of MGMA to incorporate regional cost data into the risk-sharing formula, CMS must address other design flaws, such as increasing participant flexibility, to ensure the relevance of this program under MACRA.

In addition to producing only modest results, there is a confusing overlap between CMMI's mission and MACRA implementation. As noted in the CPC+ model, CMMI refers to this as an APM, while the proposed rule for MACRA implementation has yet to be released. Therefore, the public has not had the opportunity to comment on CMS' definition of APM. CMMI continues to move forward with new initiatives without taking into account the proposed rule definition of an APM.

Conclusion

We appreciate the opportunity to submit these comments to the Subcommittee. MGMA remains committed to helping group practices and CMS understand the best way to implement MACRA in order to streamline and harmonize quality reporting programs into MIPS and develop meaningful APMs. We look forward to continuing to work with the Committee, Congress and the Administration as we begin the implementation of the new MIPS and APM programs. We've attached our comments to CMS' Request for Information and would be happy to provide you with any additional resources.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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Minority (202) 225-3641

May 13, 2016

Dr. Robert McLean
American College of Physicians
181 Rimmon Road
Woodbridge, CT 06525

Dear Dr. McLean:

Thank you for appearing before the Subcommittee on Health on April 19, 2016, to testify at the hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on May 27, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

May 26, 2016

The Honorable Joseph R. Pitts
Chairman
Energy and Commerce Subcommittee on Health
Washington, DC 20515

Dear Mr. Chairman,

I was honored by the opportunity to testify on behalf of the American College of Physicians (ACP) at the April 19th bipartisan hearing entitled, "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms." I applaud your efforts and those of your subcommittee colleagues in wanting to ensure that MACRA is successfully implemented and for inviting physician stakeholders to take part in the process.

As requested, please find herewith responses to additional questions for the record, as submitted to ACP by the subcommittee on May 13th. We look forward to working with you as implementation of MACRA continues and would be happy to serve as a resource for you, if and when needed.

Sincerely,

[redacted]

Robert McLean, MD, FACP, FACR
Member, Board of Regents

Chair, Medical Practice and Quality Committee
American College of Physicians

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Additional Questions for the Record

The Honorable Joseph R. Pitts

1. **Do you believe the threat of the SGR slowed efforts of physician organizations to develop alternative care models? Can you explain?**

The inflexible, one-size-fits-all approach to physician payments under the Sustainable Growth Rate (SGR) was arguably a major deterrent to the development of alternative payment models by certain physician organizations, but not all. One can understand how the constant threat of yearly payment cuts of nearly 30 percent under the SGR, over the course of a decade, could overshadow and inhibit any desire for exploration and/or development of new, innovative physician payment models. The American College of Physicians (ACP), however, was at the forefront of the movement to develop and fully integrate the "Patient-Centered Medical Home" model into the health care delivery system, even while contending with the burdens of the SGR system. And, that effort began long before the actual first demonstration project to test the medical home concept was initiated by Congress, under a House Republican majority, in 1996.

A Patient-Centered Medical Home is a team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes. More than a decade ago, ACP began investing countless resources into the medical home concept believing it could serve as one of the most promising models of care delivery in the future; one that would not only provide higher quality care to patients but also reduce costs to the health care system as a whole. Today, this model and its achievements are becoming more and more pervasive throughout the health care system, including its inclusion and prominence within MACRA.

ACP has also been able to develop and facilitate the testing of the Patient-Centered Specialty Practice Model, one that also is now incentivized within the MACRA law—via allowing those who participate the opportunity to receive full credit under the clinical practice improvement activities (CPIA) category of MIPS. This model is one that can serve internal medicine subspecialists, as well as other medical specialists well; however, there are a number of specialties that are still feeling left out in terms of having applicable alternative payment models available to them. Under the previous payment system, which included the consistent threat of SGR-related payment cuts, development of many alternative models was extremely challenging. Therefore, ACP is encouraged that the MACRA law offers greater opportunities for new models to be developed, tested, and ultimately rolled out.

2. **Which communication methods have been most effective for making physicians aware of, and prepared for, the changes?**

One of the most direct approaches to education for our members is through in-person meetings. ACP's Internal Medicine Meeting 2016 took place here in Washington, D.C. on May

5th to 7th. This meeting, which is held annually, brings together over 6,000 internal medicine physicians from across the country to attend more than 200 scientific sessions. During the 2016 meeting, the College provided MACRA education through several formal lectures and courses, informal briefings in our exhibit hall, press events, and multimedia displays shown throughout the entire conference. Following this meeting, we will provide recorded versions of many of these sessions to our members via our website. Other ACP in-person meetings are held by our chapters. The College has chapters in all 50 states, as well as in the District of Columbia and Puerto Rico, all of which hold meetings each year, generally starting in the Fall. MACRA-focused education and outreach will take place at all of those meetings this year in a variety of forms, including lectures, courses, and multi-media displays.

Beyond in-person meetings, a critical touchpoint for our membership and beyond is via our website, where we have created a MACRA-specific webpage. This website includes links to all of ACP's educational resources on MACRA, as well as practice support resources, and will continue to grow as the MACRA rulemaking progresses.

3. **MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sun setting and reconstituting them into a single reporting system, The Merit Based Incentive Program (MIPS). This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislation's goals of coordination and ease of reporting. Administrator Slavitt have made comments regarding Meaningful Use for example that appear to recognize this flexibility. What are your thoughts on this flexibility to eliminate duplicity reduce redundancy and increase effectiveness and simplicity in physician reporting?**

ACP very much supports efforts to eliminate redundancy and increase the effectiveness in physician reporting. Starting in 2019, the existing Medicare quality reporting/incentive programs (PQRS, Value Based Modifier, and Meaningful Use) — which vary significantly in terms of measures, data submission options, and payment timelines — will be consolidated into one single quality improvement program, the Merit-Based Incentive Payment System (MIPS), reducing the significant confusion and hassles now associated with the current three separate reporting programs. These separate Medicare reporting programs are not at all clear, transparent, or aligned in terms of performance thresholds that must be met. MACRA changes that and streamlines these programs to provide for more efficient reporting. We expect this will reduce the unnecessary regulatory burdens of complying with three different quality reporting programs, each with their own measures, deadlines, rewards and penalties.

More specifically, with regard to Meaningful Use (MU), the MACRA proposed rule has outlined a number of potential changes, including renaming the program to be the Advancing Care Information category within MIPS. These proposed changes are very encouraging as they seem to address many of the issues that have been raised with MU, such as eliminating thresholds, reducing the pass-fail nature, simplifying the base score reporting, and adding a flexible performance score component. ACP will be evaluating this category, as well as the other

components of the MIPS program, very closely and will likely be recommending additional changes to make further improvements.

Beyond MU, ACP is also appreciative of the simplification and improvements that CMS has proposed for the quality reporting category within MIPS—including reducing the number of required measures from nine to six, better organizing the measures to allow for easier selection of individual measures or a specialty measure set, encouraging outcome measurement, and automatically calculating population measures. We will continue to seek further improvements in this category aligned with our recent recommendations in response to the Draft CMS Measure Development Plan. View ACP's comment letter here.

Further, ACP was strongly supportive of the addition of clinical practice improvement activities (CPIA) to the MIPS program, which allows physicians to receive credit for quality improvement activities that many of them may already be doing—and that contribute to improving care even in advance or outside of an existing quality or resource use measure. ACP appreciates that CMS has proposed to implement this category in a non-burdensome manner, with a lot of options available for selection by physicians.

4. **MACRA, and MIPS specifically, is dependent on timely (ideally as close to real-time as possible) communication related to performance and improvement. However, many feel that current timeframes for the release of feedback reports are too long. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior. Yet, MACRA rewards physicians who make notable jumps in quality to encourage that behavior. What do you believe CMS should do to provide more rapid and accurate feedback to physicians so physicians can have the ability to act on the information?**

ACP agrees that physicians and other clinicians need to receive timely feedback on their performance—and the MACRA law does call for CMS to shorten the timeframe between performance periods, feedback reports, and subsequent payment adjustments. CMS has been providing feedback to clinicians on their performance via the current Quality and Resource Use Reports (QRURs) that are part of the Value-Based Modifier Payment program (which will soon be incorporated into the MIPS program as the cost component). However, these reports are only provided annually, with some partial information available mid-year. CMS proposes in the MACRA rule to continue to provide performance feedback on an annual basis and "may consider in future years providing performance feedback on a more frequent basis, such as quarterly." As the College noted in commenting on the RFI, CMS should make feedback reports available as frequently as possible, quarterly at a minimum but working toward monthly reports as soon as possible. Receiving data more than six months after it is reported, as is currently done with the QRURs, has little value to physicians and impedes their ability to use the data to make necessary changes to their practice to improve the quality of care for their patients. CMS acknowledges in the proposed rule that "many health care providers are still unaware of these [PQRS feedback reports and QRURs] and/or have difficulty accessing their reports in the portal. Further, we are aware that some health care providers perceive the current reports as complex

and often difficult to understand." ACP urges Congress to provide oversight to ensure that physician stakeholder organizations are given additional opportunities to provide input into the development and improvement of these performance feedback reports to ensure that information that is provided in these reports is timely and includes appropriate drill down data. It will be important that special consideration be given to the limited resources that smaller practices have to analyze the outdated, often confusing data contained in the current reports to minimize the burden placed on these practices and allow them to implement practice improvements. Thorough education of physicians on the availability of these feedback reports including information on how to use and interpret the data to make practice improvements will also be critical.

Additionally, ACP has encouraged CMS to develop a customizable dashboard that eligible clinicians would have available in their system that is refreshed with data from all reporting sources, optimally on a daily basis. CMS can look to what many private payers have already done with dashboards as examples of how to design dashboards that include usable and useful data that is available on demand for physicians. All available information should be available to the eligible clinician by query to an open API. The College is encouraged that CMS proposes in the rule "to initially make performance feedback available using a CMS-designated system, such as a web-based portal; if technically feasible perhaps an interactive dashboard." ACP encourages Congress to work with CMS to ensure that the development and implementation of these feedback tools is done with proper input from physician organizations and in a manner that allows timely end-to-end testing to occur so that problems can be addressed prior to their use.

The College also believes that it will be critical for CMS to include patient-level data in feedback reports and make them accessible from the dashboard. Having access to patient-level data allows clinicians to drill down and determine patients who are outliers and may require additional care or follow-up. Finally, including a list of patients that are attributed to the clinician/practice is important to include in any data made available to physicians.

5. **As you may know, telehealth is an issue of great interest to many of our members, including the bipartisan Energy & Commerce telehealth working group. Can the witnesses speak to their thoughts on the role telehealth can and should play in care delivery, particularly in the development of APMs?**

ACP supports the expanded role of telemedicine as a method of health care delivery that may enhance patient–physician collaborations, improve health outcomes, increase access to care and members of a patient's health care team, and reduce medical costs when used as a component of a patient's longitudinal care. The expanded role of telemedicine can be most efficient and beneficial when provided as part of an established, ongoing relationship between a patient and physician. The patient-centered medical home model (PCMH) is ideally suited to providing such a relationship, providing the convenience and tools patients want while reducing the potential for fracturing their continuity of care by seeking episodic care through direct-to-patient sites. It likewise makes sense for alternative payment and delivery system models (e.g.,

PCMHs, ACOs), that are based on value, to have a telehealth waiver (e.g., a waiver of the geographic component of the originating site requirement as a condition of payment for telehealth services) and the ability to choose the most effective and efficient way of providing the service. This waiver should be available to ACOs in all three tracks of the Medicare Shared Savings Program.

6. **Clinical data registries and certified EHRs are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare program. Can you provide your thoughts on implementing these clinical data registries and how ideally both they and EHRs will be able to meet reporting requirements? Would this represent a decrease in administrative burden?**

ACP has partnered with CE City to offer our members the ACP Genesis Registry™, which is a CMS-approved qualified clinical data registry (QCDR) for use with PQRS. As a QCDR, the Genesis Registry can include data from multiple payers, allow for continuous exchange of EHR data and benchmarking, help physicians meet the requirements of Stage 2 MU, and provide meaningful feedback reports to clinicians. This registry currently has more than 30,000 providers using it to attest to MU, and includes all of the 64 e-Measures across all 6 National Quality Strategy (NQS) domains. Calculated measures represent more than 123 million patient records. ACP also offers the PQRS Wizard–a tool that provides a step-by-step approach to help ensure that eligible professionals (EPs) meet all of the data, scoring, and attestation requirements before they submit their PQRS reports to CMS. Both of these registries are critical to ensuring physician and other clinician success in reporting on quality measures, which will continue to grow in importance as MACRA is implemented.

AmericanEHR Partners provides physicians, state and federal agencies, vendors, and funding organizations across the United States with the necessary tools to identify, implement, and effectively use EHRs and other healthcare technologies. This tool was developed by Cientis Technologies and the American College of Physicians and is dedicated to the creation of an online community of clinicians who use information technology to deliver care to Americans. Through education, social media, and the collection of peer contributed data this service organizes information to facilitate optimal decision making. AmericanEHR Partners also includes critically important MU attestation data in an easy-to-read format. Given that MU, and effective use of health information technology, is an ongoing component of both MIPS and APMs, this tool provides an invaluable service to physicians, their care teams, and other stakeholders.

These tools are designed to educate, facilitate and streamline reporting for clinicians, which is one of many steps the College is taking to reduce administrative burdens on clinicians.

7. **As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment and its importance to MIPs?**

The College strongly agrees that valid risk adjustment is essential for the success of MACRA implementation. This is true both under the MIPS pathway, within the Cost and Quality components, and within the advanced Alternative Payment Model (APM) pathway as it effects benchmarking, quality calculations, and the adequacy of various up-front (e.g. care management payment under CPC+) and back-end (e.g., MSSP shared savings) payments. As you are aware, the literature reflects the adverse effects of inadequately risk-adjusted payment models. When inadequate risk adjustment occurs, physicians and other healthcare professionals are incentivized to engage in activities that minimize the number of severely ill (e.g., multiple co-morbidities), high cost, and low socioeconomic status patients from their treatment panels. This results in decreased beneficiary access to healthcare services, and exacerbates already existing healthcare disparities. We believe that the current Medicare Hierarchical Condition Categories (HCC) risk adjustment approach is a significant improvement from previously used methodologies. We look forward to the completion of studies being conducted by the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) on the issue of risk adjustment for socioeconomic status on quality measures and resource use, and the use of this information to improve further the risk adjustment methodology currently being applied.

- **What have been your personal experiences with other risk adjustment methodologies?**

Regarding my personal experiences with other risk adjustment methodologies, it has been largely in the past year when some of the Medicare advantage plans requested that I review my charting to increase the complexity of diagnostic codes to use in office visits. I had until then not been fully aware of the significance of the use of HCC methodology to help demonstrate the complexity of caregiving to high-risk patients and the importance that that has in our payment methodologies to the Medicare advantage plans and what role that will have going forward in risk adjustment for payments to accountable care organizations.

Overall physicians are extremely under-educated on the importance of this. The challenge is that physicians spend so much time and effort adequately documenting what they're doing and they now need to take even more time and effort to find the right complex diagnostic codes to demonstrate this. It is yet another time-consuming step in many situations depending upon how one's electronic health record is set up.

However, as physicians understand the critical need to truly demonstrate the complexity of the care they deliver in this way, they will be able to better document the work that they are already truly doing. It is yet another educational process.

The Honorable Gus Bilirakis

1. **One area that is addressed by MACRA, but that will require significant guidance by CMS, is physician participation in multiple alternative payment models or APMs. We wanted**

physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow in focus – centered on a specific disease or condition.

- **Can each of you speak to why it is important to allow physicians to experiment with different quality based payments?**

  MACRA is in fact a welcomed change to the one-size-fits-all SGR payment formula because it opens up new, multiple pathways for better payment and care delivery. And, because MACRA moves us away from the volume-based care of the SGR and fee-for-service towards more innovative models of care focused on value and quality, it is important that clinicians have more choice and flexibility in their Medicare payments. For example, the College is very pleased that MACRA supports PCMHs, through both the MIPS program and as an advanced APM. Under MIPS, "certified" PCMHs qualify for the highest possible score for the clinical practice improvement activities category, which is 15 percent of the total weighted score. MACRA also directs HHS to include PCMHs as an advanced APM, without requiring that they take direct financial risk, as long as they can demonstrate the ability to improve quality without increasing costs, or lower costs without harming quality.

  Along these lines, CMS's announcement of the new *Comprehensive Primary Care Plus* (CPC+) Initiative is particularly important because it potentially will create a pathway for thousands of physician practices to incorporate the PCMH model into their practices and qualify as an advanced APM, or receive higher MIPS scores for practice improvement, as authorized by MACRA. ACP expects to ask CMS to consider other approaches to including PCMHs as advanced APMs with reduced or no risk as soon as is feasible under the law.

  Beyond the PCMH model and the new CPC+ program, it is important for Internal Medicine subspecialists and other specialists to have opportunities to experiment with different alternative payment model options. One of these options is the Patient-Centered Specialty Practice model, which is specifically identified in the MACRA law as qualifying for full credit under the clinical practice improvement category of MIPS. This model should also be considered by CMS as an advanced APM as soon as possible. Subspecialists should also be provided with clear and specific guidance from CMS as to what they will consider as other future advanced APMs. The need for this guidance is time sensitive as many organizations are working to develop and test new models now—and it would be tremendously unfortunate for them to have to re-engineer or re-start their efforts if they are not on the right track. It is also important that CMS seek immediate feedback and input on their advanced APM development guidance from practicing clinicians and specialty societies to ensure that the agency's approach is fully informed of any potential pitfalls or unintended consequences of the guidance that they are providing.

- **Can you speak to past experiences you may have had in managing different payment arrangements? How would you suggest CMS lay a positive foundation for physicians to be laboratories of care delivery?**

Given my practice situation that is mainly straight fee-for-service but with some large contracts now structured to have some shared savings (but really just starting), I really cannot say I am "managing different payment arrangements" yet.

However, I do think a foundation can be laid for physicians to be laboratories of care delivery if different payment arrangements are created in ways to allow alignment of quality improvement work, reducing work/administrative burden, and especially paying for non-face-to-face time (that is one of the greatest issues related to primary care delivery) as well as incorporating chronic care management issues.

At this point, all of those elements are quite disparate. Payment arrangements that unite and align them are critical.

2. **When we talk about payment models, there is a lot of focus on physicians, other providers, and delivery systems reforms improving quality and lowering cost. However, there is another component to the equation and that is patients. Patients will need to be involved and play an important role in helping to ensure these efforts are successful. What are your thoughts on the role patients can play to improve quality and lower costs while helping providers reform their delivery of care?**

In addition to resources aimed at helping clinicians and their practices, via our Center for Patient Partnership in Health Care, the College has also developed information to help patients and their families understand health conditions and facilitate communication between patients and their healthcare team. These resources are organized by condition, including allergies and asthma, diabetes, heart health and many others, and are available in a variety of formats including self-management guides, videos, and one- and two-page topic summaries.

ACP also offers patient care tools to assist doctors in effectively maintaining and enhancing the doctor-patient relationship and has partnered with The Wellness Network are partnering to deliver new patient education programming that will be available via The Wellness Network's Patient Channel, an in-hospital TV network and online portal.

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May 13, 2016

Dr. Robert Wergin
Board Chair
American Academy of Family Physicians
119 South C Street
Milford, NE 68405

Dear Dr. Wergin:

Thank you for appearing before the Subcommittee on Health on April 19, 2016, to testify at the hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on May 27, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

House Energy and Commerce Committee

Subcommittee on Health

Medicare Access and CHIP Reauthorization Act (MACRA) of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms

Questions for the Record

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The Honorable Joseph R. Pitts

1. **Do you believe the threat of the SGR slowed efforts of physician organizations to develop alternative care models? Can you explain?**

   Before Congress approved the MACRA, the health care delivery system emphasized fee-for-service without the appropriate support for value-based care models. Although there are systemic obstacles that hindered delivery reform, repealing the SGR was among many areas of concern.

   The AAFP remains optimistic that MACRA's implementation will foster a transition away from fee-for-service through new alternative payment models, but our message to CMS has been clear: physicians need to have reasonable qualifying standards and as few administrative burdens as possible. Through our work on the patient-centered medical home, family physicians learned that standards for qualifying needed to be manageable and achievable in all practice settings. Also, we learned that physicians who practice in rural and remote areas or small or solo practices usually need additional resources because coordination with other physicians or accessing additional resources can be difficult. The AAFP continues to review and analyze the proposed rule implementing MACRA, but we are growing increasingly concerned by the day about the potentially negative impact this law will have on solo and small group practices. We urge Congress to impress upon CMS that the final regulations should not impose unfair administrative burden and expectations on solo and small practices.

   Also, our physicians face challenges implementing Chronic Care Management code as envisioned by the Centers for Medicare & Medicaid Services (CMS). Medicare payment for this service is intended to encourage care for patients with multiple chronic conditions. Although the goals are laudable, family physicians face administrative challenges in collecting applicable Part B copayments and convincing patients to agree to pay for non-face-to-face services from their family physician. We believe this is an area deserving of immediate Congressional action. Elimination of the beneficiary cost-sharing requirements for the CCM code would substantially improve the use and impact of this important policy that is essential to primary care.

2. **Which communication methods have been most effective for making physicians aware of, and prepared for, the changes?**

   The AAFP has dedicated significant resources to educate our members through online web materials, written materials, blog posts, webinars, conference sessions, and in-person briefings. Our experience is that all these resources are important, but the most valuable way to help prepare members is through as much person-to-person information as possible. We are doing so in many venues to help educate members about MACRA and to answer their questions. The organization is also empowering members to spread the word to other physicians. We will have member education courses available at our annual meeting, called Family Medicine Experience (FMX), which attracts between 3,500 – 4,000 family physicians each year. Organizational experts and leaders are traveling to state chapters for in-person briefings.

   As an organization with over 124,900 members, we will have to evaluate message penetration. Family physicians have very busy schedules with many items competing for

their attention. Our members also work in diverse settings. Therefore, federal agencies will need to supplement and coordinate with the AAFP's outreach efforts.

3. **MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sun setting and reconstituting them into a single reporting system, The Merit Based Incentive Program (MIPS). This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislation's goals of coordination and ease of reporting. Administrator Slavitt have made comments regarding Meaningful Use for example that appear to recognize this flexibility. What are your thoughts on this flexibility to eliminate duplicity reduce redundancy and increase effectiveness and simplicity in physician reporting?**

   Concerns about administrative burdens have been a threat to patient care and practice viability for many years. During my time as a leader of the AAFP, I have heard from countless members who asked me to reduce the administrative complexity of the Medicare program and reduce, significantly, the administrative burden placed on physicians by our current regulatory structure. I believe that Congress can exercise leadership in this area by encouraging CMS to simplify the process so that physicians can focus on providing the best possible patient care.

   The AAFP supports the consolidating and streamlining of the three reporting programs into the Merit-based Incentive Payment System (MIPS), but we believe several barriers may prevent many members from successfully meeting the MIPS performance measures. The first and most significant barrier is the poorly designed Meaningful Use program – now called the Advancing Care Information program – and its lack of interoperability standards, which prohibit the sharing of patient information in a useful form. Physicians face significant challenges with their EHRs and meeting current Meaningful Use standards. Until the Meaningful Use program's criteria in the advancing care information component of MIPS is improved, and the EHR issues are resolved, it is difficult to foresee a large percentage of physicians—particularly those in small and independent practices—being successful in MACRA programs. EHRs should be a tool for success in a physician's practice, not an obstacle to overcome. Again, we urge Congress to intervene and enact legislation that would require vendors and CMS to create a health information system that worked in the interest of patients and their physicians – not the interest of the vendors who produce and sell these inadequate products to physicians and hospitals.

   As we indicated in our November 2015 letter and February 2016 comment to CMS, the AAFP supports reasonable and achievable quality measures that promote continuous improvement and reflect patient experiences. The AAFP opposes an approach that requires physicians to report on a complex set of measures that do not impact or influence the quality of care they provide to patients. Currently, 61 percent of family physicians have contracts with seven or more payers. Each has its own quality reporting, prior authorization, and appropriate use criteria. The AAFP has strongly urged CMS to streamline, harmonize, and reduce the complexity of quality reporting in the MIPS and APM programs. All measures used must be clinically relevant, harmonized among all public and private payers, and minimally burdensome to report.

   In 2014, the AAFP also engaged in a collaborative effort with CMS, America's Health Insurance Plans (AHIP), and representatives from the patient community to identify and develop a set of core quality measures for primary care physicians. Our collaboration was

supported by the National Quality Forum and the National Committee for Quality Assurance to ensure that our work was adhering to the most recent science and evidence on quality and performance measurement. We are pleased with the preliminary outcomes of the process. The AAFP has recommended in numerous communications that CMS should use the core measure sets developed by the multi-stakeholder Core Quality Measures Collaborative to ensure alignment, harmonization, and the avoidance of competing quality measures among payers. Additionally, the AAFP strongly believes CMS should utilize and implement the Core Measure sets agreed to through the Core Measures Collaborative for inclusion in MIPS and APMs.

Although CMS has taken steps to ease burdens in some areas, we are deeply concerned that the regulatory process may inadvertently create addition requirements for physicians. Successful MACRA implementation must include significant flexibility and process simplification. We are especially concerned that the regulations, as proposed, will have an unfair negative impact on solo and small group practices. Congress must communicate with CMS that the final regulations must not unfairly impact these physicians and practices. This message cannot be reinforced enough. We welcome the opportunity to work with CMS and the Committee to ensure that true regulatory flexibility is realized as an integral element of MACRA implementation.

4. **MACRA, and MIPS specifically, is dependent on timely (ideally as close to real-time as possible) communication related to performance and improvement. However, many feel that current timeframes for the release of feedback reports are too long. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior. Yet, MACRA rewards physicians who make notable jumps in quality to encourage that behavior. What do you believe CMS should do to provide more rapid and accurate feedback to physicians so physicians can have the ability to act on the information?**

For the MIPS to be successful, it is imperative that CMS send timely, accurate, and actionable feedback to physicians. To date, CMS' feedback on the Patient Quality Reporting System, Quality Resource Use Reports, and Value-Based Modifier programs is sent one to two years after the reporting period, thus minimizing its clinical improvement value. It is totally unacceptable for CMS to expect providers to install the most up-to-date technology, report performance date within 90 days after the close of the reporting period, and monitor performance and make improvements in real time while the agency fails to install or develop software and technology that will allow analysis of the data and feedback in a timely manner. If CMS is unable to collect, aggregate, and transmit data in a timely manner to physicians, then how can they expect physicians to improve their quality and efficiency at an accelerated rate. Our members and CMS should be partners in these areas and we need our partner to improve their performance. Absent such action by CMS, the implementation of this rule should be delayed by Congress to allow adequate time for CMS to institute and test these changes.

A primary care provider's ability to improve performance relies heavily on the availability of timely, accurate and actionable quality and cost data on all physicians and providers who care for their attributed population. Besides managing costs and quality for any referrals, understanding current performance is critical to monitoring improvement and understanding where continuous improvement is needed. It is only when a provider has access to these data that they can be responsible for overall performance.

5. **As you may know, telehealth is an issue of great interest to many of our members, including the bipartisan Energy & Commerce telehealth working group. Can the witnesses speak to their thoughts on the role telehealth can and should play in care delivery, particularly in the development of APMs?**

   As my written testimony indicates, primary care physicians treat patients across the spectrum and without regard to age, gender, or disease category. In some communities, the family physician is the only physician within hundreds of miles.

   Telehealth could play an important role in helping physicians coordinate health services such as referrals. Also, with established patients, telehealth could support care continuity that is convenient, patient-centered and involves less time and travel, particularly for patients that have multiple, often chronic, conditions.

   Most importantly, telehealth can help increase access to care for patients in rural, underserved areas of the country. Physicians in rural communities and their patients often have limited access to specialists, particularly mental health professionals. Telehealth consultations with psychiatrists, especially child and adolescent specialists, could help enhance patient care. Telehealth could also improve dermatological services. Of course, the value of increased access and convenience is not limited to rural or underserved areas of the country.

   All told, telehealth services have the potential to improve patient outcomes, lower costs, and reduce fragmentation. These are all essential elements of the value-based systems supported within alternative payment models. Ongoing evaluation and study are needed to ensure these potentials become realized.

6. **Clinical data registries and certified EHRs are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare program. Can you provide your thoughts on implementing these clinical data registries and how ideally both they and EHRs will be able to meet reporting requirements? Would this represent a decrease in administrative burden?**

   Ultimately, registries should be important tools for improving patient management and reducing administrative burdens. The AAFP encouraged CMS to choose reporting options that require the least burden. Instead of overly focusing on the reporting of quality measures, CMS should keep the focus on a continuous process for clinical improvement.

   Ultimately, Qualified Clinical Data Registry-based (QCDR) reporting may be the least burdensome as work is done "behind the scenes." However, the set -up for a QCDR is time-consuming and a costly investment for the practice. Though the EHR reporting option, in theory, should be less burdensome, practices continue to find it difficult to work with EHR vendors. Also, our members report many concerns with this reporting option. While claims data may be all that is available right now, CMS should pursue pathways that allow for the reporting of clinical data. Despite the lack of a perfect reporting option, CMS should encourage quality reporting focus on care delivery and quality measures, not on the technology used for reporting. We would encourage Congress to place the appropriate pressure on vendors to produce products that allow for this type of performance improvement.

7. **As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment and its importance to MIPs?**

   - **What have been your personal experiences with other risk adjustment methodologies?**

   It is important, when discussing risk adjustment, to recognize that patients cared for by family physicians – especially Medicare patients – are usually complex due to multiple diagnoses, independent of any social determinants of health. Most Medicare patients seen by family physicians have one or more chronic conditions and require intensive primary care services both to manage their current disease state, and to prevent the onset of others. The complexity of the patient should be the first risk adjustment.

   As we indicated in our comment to CMS (42 CFR 414), the AAFP supports reducing health disparities as a part of care delivery and urges CMS to move forward with expanding its risk-adjustment methodology in quality measures to incorporate social and economic factors, such as race, income, education, and region. Risk-adjusting for socioeconomic status ensures the measures are fair and sets the standard for comparison of physician performance by adjusting for factors outside of the physician's control. Not adjusting could lead to misleading conclusions about physician performance. As a result, further disparities in care could be magnified. Through HealthLandscape, the AAFP has developed the Community Vital Signs tool that could assist practices of all sizes to understand the social and economic status of their patient population.

   With a focus on health outcomes, practices will need an infrastructure that supports population health management and risk-stratified care management, which begins with attributing patients to their primary care physician. By identifying panels, physicians, and their care teams can risk-stratify patients based on the individual care and support needs of each patient, thereby allowing for a current state assessment of the health of the population and a gap analysis of resource needs. For those patients with complex or multiple conditions, the primary care physician and care team will need to collaborate with any specialists, care provider, or community organization providing care to the patient to ensure ongoing, timely and effective communication and coordination of care. Utilizing processes and coding such as Transitional Care Management (TCM) and Chronic Care Management (CCM) will assist in the implementation of new processes and may provide additional funding to support those changes.

The Honorable Gus Bilirakis

1. **One area that is addressed by MACRA, but that will require significant guidance by CMS, is physician participation in multiple alternative payment models or APMs. We wanted physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow in focus – centered on a specific disease or condition.**

   - **Can each of you speak to why it is important to allow physicians to experiment with different quality based payments?**

   - **Can you speak to past experiences you may have had in managing different payment arrangements? How would you suggest CMS lay a positive foundation for physicians to be laboratories of care delivery?**

   As the law is currently written, the definition of an Alternative Payment Model for participation in the Advanced APM program is very narrow. The qualification and eligibility criteria are complicated and exclusive and, we believe, will result in most providers entering the MIPS program in 2019. In our opinion, this violates the intent of the law and we encourage Congress to strongly urge CMS to broaden the definition of qualified and eligible APMs to allow for more participation in these different payment models – specifically the medical home model – by family physicians. Furthermore, we believe CMS should address varied APMs with significant caution. Experimenting with different APMs can be a positive thing because one size does not fit all. However, there seems to be a rush among stakeholders to create narrowly focused APMs centered on specific diseases or conditions. Our concern is that a myriad of disease or condition-specific APMs will fragment care under APMs the same way that it is currently fragmented under the fee-for-service system. As this process moves forward, our vision for health delivery reform should be centered on achieving the Triple Aim of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Only APMs built on a foundation of primary care will achieve those goals.

2. **When we talk about payment models, there is a lot of focus on physicians, other providers, and delivery systems reforms improving quality and lowering cost. However, there is another component to the equation and that is patients. Patients will need to be involved and play an important role in helping to ensure these efforts are successful. What are your thoughts on the role patients can play to improve quality and lower costs while helping providers reform their delivery of care?**

   Patients have an important role to play in achieving the Triple Aim. The health care system can support patient engagement through value-based insurance design. Effective programs encourage patients to engage in health-seeking behavior by reducing or eliminating patient cost-sharing, encouraging preventive care, and rewarding patients for improving outcomes.

   A value-based health care system will require physicians and payers to embrace the concept of patient-centered care. This concept is the foundation of primary care, the Patient-Centered Medical Home (PCMH) model of care, and other successful delivery reforms. In fact, by acknowledging the patient as the focal point in a PCMH, with a personal physician working with a team to coordinate care, we know we can positively impact a patient's overall

health while constraining health spending. In PCMH pilots, both in the private sector as well as in Medicaid programs, it has been demonstrated that the PCMH model creates significant savings to the system. It also has been shown that paying for on-going care management is essential to enable physicians to provide the most effective patient care.

Improving access to primary care also will be an invaluable tool for patient engagement and health promotion. Research indicates that when patients have a continuous source of health care, their outcomes are better, and lower costs across-the-board. The AAFP will continue to support better tools for evaluating patient satisfaction and supporting the doctor-patient relationship. Reducing administrative burdens will certainly be invaluable in our efforts to achieving those two goals.

Improving interoperability will be an essential tool help physicians address important population health issues, promoting safety, and patient satisfaction. System interoperability, the ability to share and utilize information between two or more information systems, is critical in today's increasingly interconnected health care environment. Yet significant challenges continue to impede true information reciprocity across the spectrum of care. The AAFP understands that removing these roadblocks and eliminating isolated data silos are essential steps toward improving care quality, safety, and efficiency. That is why we support ongoing efforts aimed at creating and implementing technical standards for the secure and effective transfer of health data. We have also been engaged in the equally important task of developing process policies for how patient information is shared between providers, payers, and others. The issue of interoperability represents one of the most complex challenges facing the health care community as we pursue patient-centered health care reform. For that reason, the AAFP will continue working to bring vendors, providers, payers, and policymakers together behind a common vision of true interoperability and connected care that benefits patients and their primary care physicians. We would urge Congress to do likewise.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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May 13, 2016

Dr. Barbara L. McAneny
American Medical Association
25 Massachusetts Avenue, N.W.
Washington, DC 20001

Dear Dr. McAneny:

Thank you for appearing before the Subcommittee on Health on April 19, 2016, to testify at the hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on May 27, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

AMA
AMERICAN MEDICAL ASSOCIATION

BARBARA L. MCANENY, MD
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May 27, 2016

The Honorable Joseph R. Pitts
Chairman
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Pitts:

On behalf of the physician and medical student members of the American Medical Association (AMA), I want to thank you again for the opportunity to provide our views on the Medicare Access and CHIP Reauthorization Act (MACRA). We commend you and the Members of the Subcommittee on Health for addressing important implementation issues to ensure that physicians are prepared for the new Medicare payment reforms.

Attached to this letter are our responses to your supplemental questions from the April 19, 2016 hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms." If you have any further questions or need additional information, please contact Aiken Hackett, at aiken.hackett@ama-assn.org or (202) 789-7475. We look forward to working with you and the Subcommittee to ensure that MACRA implementation is a success for patients and physicians.

Sincerely,

[redacted]

Barbara L. McAneny, MD

Attachment
cc: James L. Madara, MD

Responses of the AMA to Supplemental Questions from the House Committee on Energy and Commerce, Subcommittee on Health

The Honorable Joseph R. Pitts

1. **Do you believe the threat of the SGR slowed efforts of physician organizations to develop alternative care models? Can you explain?**

   As a practicing physician, I felt the burden of the broken SGR payment system for many years. With half of my patients covered by Medicare, the threat of significant payment cuts was very real and jeopardized the viability of our practice every year. I could not justify hiring people to develop alternative care models or improve patient care when I would have to lay them off if the Medicare payment reductions went through. This constant threat of cuts discouraged many physicians from dedicating resources towards innovation or devoting time to developing new care models.

2. **Which communication methods have been most effective for making physicians aware of, and prepared for, the changes?**

   Effective communication methods vary since physician practices differ in their resources and level of understanding of new requirements. Accordingly, physicians need both basic information and more detailed tools to prepare for significant changes. The AMA has tried to provide both of these types of materials to assist in understanding MACRA. We have created plain language interpretations of the law and have also formed taskforces of medical state and specialty societies to drill down and discuss specific details of MACRA.

   Physicians also need the requirements to be placed into context of their practices. To do this, the AMA has an extensive practice transformation platform, known as Steps Forward, which offers Continuing Medical Education (CME) training modules for physicians and their practice administrators on many issues related to MACRA, including implementation of electronic health records (EHRs) and improving team-based care. We also are developing a free payment model evaluator for physicians and practice managers to assess practice readiness, and provide implementation resources for the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). We hope that CMS will not create too high of a bar for APMs but will encourage and allow innovative models to count under MACRA.

   Finally, physicians and their representatives need a direct line of communication with the agency and officials who are implementing the changes. Oftentimes, unique questions arise that require guidance from those who are implementing the law. To date, the Centers for Medicare & Medicaid Services (CMS) has worked with the AMA to listen to our concerns and work towards a successful implementation of MACRA. We, however, want to continue to push the agency for clear answers and enhanced access to data to succeed under the new law.

3. **MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sun setting and reconstituting them into a single reporting system, The Merit Based Incentive Program (MIPS). This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislation's goals of coordination and ease of reporting. Administrator Slavitt have made comments regarding Meaningful Use for example that appear to recognize this flexibility. What are your thoughts on this flexibility to eliminate duplicity reduce redundancy and increase effectiveness and simplicity in physician reporting?**

   The AMA strongly agrees that MIPS offers significant improvements over the current system due to the flexibility provided in the law. By creating a single performance reporting program, MACRA

creates an opportunity to reset and improve quality measurement as well as the other reporting requirements. Specifically, MIPS has the ability to streamline measures, reduce reporting burden, create flexibility to report on clinically relevant measures, encourage participation, and overall improve care. Given this opportunity to improve current reporting programs, the medical community would have serious objections to any proposal that merely moves the current incentive programs into MIPS. The goal of MIPS should be to create a new program with a limited set of requirements but with more options for meeting those requirements. Success should be counted in terms of how many physicians have an opportunity to participate in and be judged on initiatives that really matter.

4. **MACRA, and MIPS specifically, is dependent on timely (ideally as close to real-time as possible) communication related to performance and improvement. However, many feel that current timeframes for the release of feedback reports are too long. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior. Yet, MACRA rewards physicians who make notable jumps in quality to encourage that behavior. What do you believe CMS should do to provide more rapid and accurate feedback to physicians so physicians can have the ability to act on the information?**

   The AMA strongly agrees that access to information and feedback is necessary to be successful in MACRA. Current feedback reports provided by CMS are out of date and lack key details to understanding the methodologies used to arrive at the benchmarks and other calculations made. This creates frustration and distrust, and must be avoided going forward.

   To improve feedback reports, CMS should include the ability to see high-level, overall performance information, as well as drill down tables with individual patient information. Where appropriate, CMS should aim to display feedback and performance measurement information in graphic form with additional details displayed elsewhere to improve comprehension. CMS must also be forthcoming in regard to the methodologies used to comprise any benchmarks or attribute patients for a particular measure. This information must be clearly identified and easy to interpret. Where there is a dispute about the accuracy of the data, CMS should ensure an open line of communication with the practice or physician to reconcile any potential errors.

   Lastly, CMS should consult stakeholder groups continuously to determine the best presentation and most meaningful format for sharing ongoing, actionable performance feedback information with physicians and practices. As technology is constantly changing, it will be critical for CMS to take an ongoing approach to improving the way performance information is disseminated to physicians and practices. Stakeholders must be included in this process so that feedback can be provided in a format that works best for physicians and is meaningful to their practice's ongoing improvement activities.

5. **As you may know, telehealth is an issue of great interest to many of our members, including the bipartisan Energy & Commerce telehealth working group. Can the witnesses speak to their thoughts on the role telehealth can and should play in care delivery, particularly in the development of APMs?**

   Telehealth and health information technology (health IT) will be essential tools for both MIPS and APMs. The integration of telehealth technologies into existing clinician health IT systems will be essential to reap the benefits of reducing access barriers to medical care. The integration of telehealth and health IT tools can maximize the benefit of healthcare resources and provide flexible opportunities for patients to engage with clinicians and better self-manage their care. They can also increase access to medical care not only for geographically remote and traditionally underserved populations but remove barriers that many patients face while also improving affordability. Efforts to

improve care coordination will depend on these tools to be able to transmit and incorporate data and provide new lines of communication across care settings.

One of the biggest barriers to greater adoption of telehealth is the lack of Medicare payment. APMs are no longer restrained by the antiquated Medicare geographic, originating site, and technology restrictions on coverage. In addition, it is expected that new technologies that support or enable telehealth options will only continue to grow. APMs offer an opportunity to provide telehealth services with demonstrated clinical benefit to more Medicare beneficiaries, which will drive further innovation.

6. **Clinical data registries and certified EHRs are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare program. Can you provide your thoughts on implementing these clinical data registries and how ideally both they and EHRs will be able to meet reporting requirements? Would this represent a decrease in administrative burden?**

Both clinical data registries and EHRs can facilitate data reporting and improve feedback to physicians. Specialty societies have improved the relevance of quality reporting by developing measures that are more clinically appropriate for specific physicians. Registries also provide more actionable and timely information back to physicians on their performance and, in some instances, include data from multiple payers, which can offer a more comprehensive picture of the care provided. EHRs, when implemented appropriately, can also improve reporting by automating the process for collecting and sending data.

Allowing reporting through both options can help decrease administrative burden. Physicians, however, should be allowed to pick the most appropriate reporting option. For example, a physician may be able to identify clinically relevant electronically specified (e-specified) measures that can be reported through an EHR but also might identify a few other relevant measures that are not yet e-specified and can only be reported through a registry.

7. **As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment and its importance to MIPs?**

    - **What have been your personal experiences with other risk adjustment methodologies?**

Certain measures today are irrelevant for many physicians—either because no patients get attributed to them or because they had little to no opportunity to influence the costs that are attributed to them. Shortcomings in the attribution and risk adjustment methodology exacerbate the problem and limit the appropriateness of these measures to evaluate care quality. Current methodologies also do not adequately protect against cases where one very bad patient outcome can inappropriately skew the data. For example, where, in one month, there are a small number of patients who just happen to be diagnosed with the same serious condition and this drastically changes the data for that period.

More appropriate risk adjustment will help improve the relevance and accuracy of the MIPS program. If properly selected and designed, measures tied to episodes of care could increase the reliability and applicability of resource use measures and make physician feedback reports more actionable. In addition, adjustments to the methodology should take into account the time needed to change patient behavior and should not include activities that are outside of the physician's control. This would also offer an opportunity to adapt risk adjustment and attribution methodologies to the individual

condition or service being measured. Overall, this would create a MIPS program that is more accurate and relevant to improving care.

The Honorable Gus Bilirakis

1. **One area that is addressed by MACRA, but that will require significant guidance by CMS, is physician participation in multiple alternative payment models or APMs. We wanted physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow in focus – centered on a specific disease or condition.**

   - **Can each of you speak to why it is important to allow physicians to experiment with different quality based payments?**

     The AMA views the establishment of the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and the development of physician-focused APMs as critical components of MACRA. We see physician-focused models as an opportunity for major transformation in the delivery of care for patients with serious conditions. For example, a diabetes APM that reduces complications and hospitalizations, improves patient self-management, and slows disease progression, would be a major advance for Medicare patients. Likewise, new models for managing cancer patients' care can improve outcomes through more accurate diagnosis and staging and better treatment planning. Allowing physicians to experiment with these different models will encourage innovation in treatments while address some of the most challenging diseases and problems in health care. We are urging CMS to allow these physician models to qualify as APMs under MACRA. Two-sided financial risk should not be required in all models since this may limit the ability for physicians to experiment with different quality based payments.

   - **Can you speak to past experiences you may have had in managing different payment arrangements? How would you suggest CMS lay a positive foundation for physicians to be laboratories of care delivery?**

     My own experience with APMs has shown that when physicians have the opportunity to innovate, these models can be successful. In 2012, I received a Center for Medicare and Medicaid Innovation (CMMI) grant to replicate across the country, how my practice was providing cancer patients with better care at a lower cost. By implementing a medical home, we were able to cut hospitalizations in half and create a model for chronic care management that could be replicated by other practices.

     To lay a positive foundation, CMS should provide physicians with access to data, in an easily understandable format, to help them develop appropriate and successful models. Physicians do not know what other services their patients receive from hospitals, labs, and other physicians and providers—making it impossible to complete APM proposals without this information. In addition, CMS should establish a clear pathway for physician-focused payment models, particularly those that are proposed to the PTAC to be implemented by CMS as qualified APMs.

2. **When we talk about payment models, there is a lot of focus on physicians, other providers, and delivery systems reforms improving quality and lowering cost. However, there is another component to the equation and that is patients. Patients will need to be involved and play an important role in helping to ensure these efforts are successful. What are your thoughts on the**

role patients can play to improve quality and lower costs while helping providers reform their delivery of care?

Patients play a key role in ensuring the success of MACRA. The AMA believes MACRA can create a new system that is more patient-centric and encourages patient engagement in their care decisions. MACRA provides patients with key opportunities through better data sharing, innovative care models, and improved health IT. In particular, the AMA believes patients should work with physicians to improve quality reporting by creating patient experience and care coordination measures. Including patient engagement as part of the quality development and reporting process ensures that providers put patient needs first.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

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Minority (202) 225–3641

May 13, 2016

Dr. Jeffrey W. Bailet
Executive Vice President
Aurora Health Care
3000 West Montana Street
Milwaukee, WI 53215

Dear Dr. Bailet:

Thank you for appearing before the Subcommittee on Health on April 19, 2016, to testify at the hearing entitled "Medicare Access and CHIP Reauthorization Act of 2015: Examining Physician Efforts to Prepare for Medicare Payment Reforms."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on May 27, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

The Honorable Joseph R. Pitts

1. **Do you believe the threat of the SGR slowed efforts of physician organizations to develop alternative care models? Can you explain?**

   Yes, the unpredictability caused by the SGR and the need to craft a "doc fix" every year stymied physician efforts to fully embrace value-based alternative payment and delivery models. Every year the pending expiration of SGR created a cloud of uncertainty hanging over practitioners across the nation who were forced to try to deal with the constant threat of drastic reductions in Medicare physician payment. Thanks to the Committee on Energy and Commerce's leadership for taking action to address this seemingly never-ending problem by passing MACRA, physicians can now turn their focus and attention away from the annual threat of Medicare cuts and direct their full efforts to improving the quality of patient care through care redesign, more effectively managing chronic illness and making the necessary infrastructure changes needed to be successful with the implementation of MIPS and alternative payment models. The new payment system provides stability as well as necessary incentives to move toward payment and delivery models that improve care for patients. MACRA was a milestone in Medicare physician payment policy by driving value-based care through existing programs and new payment models. However, physicians and other stakeholders must continue a robust dialogue with Congress and CMS to ensure this monumental undertaking succeeds.

2. **Which communication methods have been most effective for making physicians aware of, and prepared for, the changes?**

   Aurora Health Care, like many high-performing health systems, are actively working to develop tools to help physicians and caregivers prepare for MACRA and its implementation, including making substantial investments in areas that can help drive two-way communication between front-line physicians and physician and administrative leadership that informs, educates and enhances the awareness of what is necessary to improve the quality of care while keeping costs in check or reducing costs without degrading quality. Specialty societies and medical associations too are creating educational platforms by way of roundtables, webinars, detailed educational materials, and other leadership forums to assist healthcare leaders particularly, but also front-line physicians learn about the changes needed to be successful as MACRA comes on line.

   Equally, if not more important is the need for health care and policy leadership to create communication methodologies that engage physicians in ways where the needed transformational changes are being done with them, not to them. Maximizing the success of MACRA will only be possible with an engaged physician and caregiver workforce that's forward looking and invested in making the needed practice changes along with adoption of a culture of continuous quality improvement. The willingness of CMS and Congress to enlist physician and other stakeholder feedback is greatly appreciated and needs to intensify once the HHS Secretary finalizes the rules for MIPS and alternative payment models.

   Notwithstanding the above, it will take time to educate and provide the tools for front-line physicians to be successful in providing high quality, value-based care. Communication

methodologies need to be flexible and customized recognizing front-line physicians are in various stages of readiness to be successful in a value-based reimbursement system.

3. **MACRA provided great flexibility in its effort to streamline the three major physician quality reporting systems. It did this by sun setting and reconstituting them into a single reporting system, The Merit Based Incentive Program (MIPS). This provides CMS an opportunity to reevaluate these programs and make changes to them that furthers the legislation's goals of coordination and ease of reporting. Administrator Slavitt have made comments regarding Meaningful Use for example that appear to recognize this flexibility. What are your thoughts on this flexibility to eliminate duplicity reduce redundancy and increase effectiveness and simplicity in physician reporting?**

   Flexibility and simplicity are, and will continue to be, paramount in unburdening physician practices, a global challenge if not addressed, leads to physician burnout and disengagement. In large measure, active listening to physicians and stakeholders as the transformation to value-based care delivery advances will drive meaningful flexibility and simplicity. In addition, the measurement parameters that physicians and clinicians will be held accountable to achieve need to be critically thought through to ensure they maximize patient benefit and respect the associated financial ramifications while limiting unintended negative consequences. Performance measures and reporting requirements need to be structured in ways that maximize the principle that the practice focus and resources are deployed to benefit the patients not spent supporting inflexible, duplicative or redundant requirements degrading clinical efficiency and effectiveness.

   As the regulations are developed, I encourage CMS to continue to engage the stakeholder community, including provider groups, patient advocates, specialty societies, medical associations, payers, and others. The health care provider community is eager to share its insights with CMS and, to date, CMS has made a sincere effort to listen.

4. **MACRA, and MIPS specifically, is dependent on timely (ideally as close to real-time as possible) communication related to performance and improvement. However, many feel that current timeframes for the release of feedback reports are too long. This delay means that physicians are already well into the next reporting cycle and have no opportunity to change their behavior. Yet, MACRA rewards physicians who make notable jumps in quality to encourage that behavior. What do you believe CMS should do to provide more rapid and accurate feedback to physicians so physicians can have the ability to act on the information?**

   MIPS combines existing, separate programs into a single payment adjustment mechanism. Aurora Health Care shares the goals of the law in driving towards a robust value-based payment system. In transitioning from the current reporting and value-based payment programs, we urge CMS to carefully assess the integration of existing programs. It is imperative that a seamless, coherent transition occurs into the MIPS. As such, we ask CMS to integrate the programs through improvements that will eliminate obstacles, streamline reporting, enable interoperability and minimize administrative burden to providers.

5. **As you may know, telehealth is an issue of great interest to many of our members, including the bipartisan Energy & Commerce telehealth working group. Can the witnesses speak to their thoughts on the role telehealth can and should play in care delivery, particularly in the development of APMs?**

   MACRA will help unleash innovation by providing the needed incentives for physicians to adopt more efficient ways of providing care, including the utilization of innovative technologies such as telehealth. Telehealth offers a green field of opportunity to rethink care delivery in a way that is patient-centered and promotes care coordination and communication. With telemedicine, we will be able to increase patient touches and the frequency of those touches, and other new emerging technologies such as remote patient monitoring will allow us to be more informed about the patient's actual state of health. Regarding patient engagement, CMS must recognize and account for the variety of patient engagement activities that integrated delivery systems such as Aurora may use to connect a provider to a particular patient. This can include virtual care, which may be new for patients. These new systems and technologies need to be recognized and fully incorporated into APMs. With these changes, doctors will interact with the patients in ways that may be new and unfamiliar to them so new APMs must foster a rich culture of learning that promotes the adoption of these new technologies.

6. **Clinical data registries and certified EHRs are envisioned by MACRA as serving as critical reporting mechanisms for providers to interact with the Medicare program. Can you provide your thoughts on implementing these clinical data registries and how ideally both they and EHRs will be able to meet reporting requirements? Would this represent a decrease in administrative burden?**

   The successful use of information technology to harness new data in actionable and meaningful ways to impact health outcomes will be vital for ensuring MACRA reaches its full potential. Electronic health records are a small piece—the seeds, but there needs to be improved infrastructure to make meaningful strides in improving patient care and bending the cost curve.

   It is simply not enough to purchase an electronic health record (EHR) system. The data collected by these systems must be analyzed and interpreted in ways that, when reflected back to physicians and their care teams, it is meaningful and actionable and helps care teams deliver the highest quality of appropriate care and value to patients. This also ensures best practices, once identified, can be disseminated across the entire healthcare system through shared learning and collaboration.

   The infrastructure requirements to support clinical data registries and certified EHRs in terms of personnel, hardware, software licenses, registry maintenance, data analysis and user education are immense and place huge financial and administrative burdens on physicians especially those in single and small group practices who have limited access to financial and infrastructure assets.

In our current state, without robust interoperability, and additional financial recognition for developing these needed infrastructure system and processes, there is clearly an increased financial and administrative burden placed on physicians and healthcare systems. In the future, as this infrastructure becomes fully integrated into the fabric of the practice and additional financial recognition is provided for the value enhancements clinical registries and certified EHRs deliver, the financial and administrative practice burdens will begin to materially fade.

7. **As you know, failure to appropriately apply risk adjustment can inappropriately penalize providers who care for high risk or complicated populations which is why MACRA allowed for a professional to see their MIPS score adjusted – what are your thoughts on the successful implementation of risk adjustment and its importance to MIPs?**

CMS must be especially attentive to the impact of sociodemographic factors on performance measures used in MIPS and APMs. CMS should incorporate sociodemographic adjustment when necessary and appropriate. The evidence continues to mount that sociodemographic factors beyond providers' control – such as the availability of primary care, behavioral health services, physical therapy, easy access to medications and appropriate food, and other supportive services – influence performance on outcome measures.

- **What have been your personal experiences with other risk adjustment methodologies?**

Aurora's integrated delivery system includes several community hospitals located in rural areas, urban hospitals, a psychiatric hospital, and Aurora St. Luke's Medical Center, Wisconsin's largest hospital with more than 700 beds and home to world class cardiovascular and neuroscience programs, which provide complex neuro, heart and vascular surgical, and minimally invasive care. Our diverse and unique patient populations have provided us with an appreciation of the complexities of attempting to utilize a "one-size-fits-all" approach when it comes to risk adjustment approaches.

For instance, it is unfathomable yet conceivable under the new Medicare reimbursement system that some providers may be forced to contemplate avoiding treating patients who have complicated medical problems and decreased probability of recovery because they are more likely to lower the providers' performance scores. Additionally, providers may avoid treating disadvantaged populations for fear that they are less likely to comply with treatment plans, which could also drag down the provider's performance scores. Exacerbating this issue is the fact that safety-net hospitals and physician groups often have low or zero profit margins, so financial penalties for poor performance could jeopardize their business, thereby further reducing access to care for these populations.

The Honorable Gus Bilirakis

1. **One area that is addressed by MACRA, but that will require significant guidance by CMS, is physician participation in multiple alternative payment models or APMs. We wanted physicians to be able to experiment with different approaches to improving their practices while also recognizing that many APMs being developed by stakeholders are somewhat narrow in focus – centered on a specific disease or condition.**

   - **Can each of you speak to why it is important to allow physicians to experiment with different quality based payments?**

   As the direction of various payment models evolve, it will be important for providers to have the opportunity to try out and then expand new payment approaches that are successful in rewarding improved patient outcomes and smarter spending. Sophisticated multispecialty medical groups manage a diverse array of medical and surgical illnesses. Anticipating that some alternative payment models in development could be narrowly focused, allowing physicians to participate in multiple alternative payment models enables the full breath of the practice to actively participate in value-based care delivery. The purpose of payment reform is not to go from one bucket of payment to another but to encourage innovative approaches to unlocking the power of health care data, and finding new ways to coordinate and integrate care to improve quality and bend the cost curve. Expanding the number of primary and specialty physicians who become actively engaged in driving this transformation accelerates this innovation. Congress and CMS must ensure that an environment exists that promotes and fosters this type of behavior and removes any structural regulatory impediments that may discourage physicians and delivery systems from fully embracing value-based care delivery including alternative payment models.

   - **Can you speak to past experiences you may have had in managing different payment arrangements? How would you suggest CMS lay a positive foundation for physicians to be laboratories of care delivery?**

   Having been a leader of a moderately sized multispecialty medical group associated with a large university in a major city that experienced near financial collapse within 18 months of assuming full risk due to limited population management infrastructure, an incomplete specialty network leading to significant 'out of network' exposure and limited alignment with a hospital system for inpatient services, it is imperative that regulators appreciate the need to proceed cautiously during this transition. Medicare largely has been based on fee-for service payments since its inception and many physicians are in various stages of readiness for a value-based payment system. While systems such as Aurora and our physicians have early experience with value-based payment structures, there is and will continue to be a significant learning curve as providers begin to take on financial risk. Also regulators need to recognize that while the trend of hospitals and health systems employing physicians continues to accelerate, many employed physician groups remain a federation of practices, rather than high-performing fully integrated and unified medical groups. This need for integration is another reason why CMS should recognize that health care systems will need time to adapt and learn how to function in this new payment environment. Providing an incremental

approach that includes flexibility and rational exposure to financial risk will be vital in ensuring a successful transition to value-based payment. Congressional oversight of this process would be needed and welcomed.

2. **When we talk about payment models, there is a lot of focus on physicians, other providers, and delivery systems reforms improving quality and lowering cost. However, there is another component to the equation and that is patients. Patients will need to be involved and play an important role in helping to ensure these efforts are successful. What are your thoughts on the role patients can play to improve quality and lower costs while helping providers reform their delivery of care?**

It is absolutely essential to empower patients to be partners in the transformation to value-based care delivery. Patient engagement is one of the most important guiding principles for ensuring MACRA is successful. Under new value-based care models, patients will move from passive receivers of care to active, informed participants making individual care and purchasing decisions. The underpinnings of the APM models are designed to improve and enhance patient care by advancing the quality spectrum forward improving patient outcomes. Included in the design of APM's is the ability to more effectively capture meaningful and actionable data and measurements providing new ways to analyze different patient populations and gauge impactful care redesign opportunities for specific cohorts of patients. Essential to these care redesign efforts are patients needing to take more ownership of their care. Doctors and other providers will be connecting with patients in significantly different ways including virtual care and team based care approaches and active patient engagement is vital to making these new care models successful.

In summary, active patient engagement will be key to a successful transformation of our health care system that more effectively utilizes resources and rewards outcomes. Patients can have the most impact by making sure they are keeping themselves healthy through preventative care, and making sure they have regular access to care. Physicians must realize this and encourage their patients to be more proactive and assertive in keeping themselves healthy; including preventing emergency health events through preventative care approaches such as wellness visits and regular screenings.

3. **Dr. Bailet, you have been able to oversee many diverse payment models, and have experiences with models that were successful and others that were not. Allowing this experimentation with payment models is a goal of MACRA.**

   - **Can you speak to efforts that you believe are critical to ensuring progress is being made in sharing best practices and promoting a culture of learning so that others can learn what works or where difficulties were encountered?**

A strong culture of learning and collaboration among practices of all sizes and specialties will be needed to make MACRA a success in improving patient care and bending the cost cruve. Aurora has been very active in collaborative activities with partners of all sizes. In 2014, for example, Aurora helped found AboutHealth, a clinically integrated network that

enhances clinical quality, increases efficiency, and improves customer experiences through shared practices. This network provides access to care for about 94 percent of Wisconsin's population and serves patients in Illinois, Iowa, Michigan and Minnesota. By creating a strategic partnership with other high performing healthcare systems in our region, we are able to build upon and advance clinical quality, efficiency and patient experience. For example, in 2015 and 2016, AboutHealth is focusing on the following 5 quality initiatives: Diabetes Mellitus type 2; Central Line Infections; Post-Operative Mortality; Patient & Family Centered Care; End of Life Care/Advance Care Planning; Total Knee Arthroplasty; Back Surgery; and, Ischemic Vascular Disease. All work done on these initiatives is not only implemented by the physicians in the member organizations, but also the physician networks of these member organizations. As a result, smaller practices have an opportunity to collaborate with larger systems to improve patient outcomes. AboutHealth is an example of how partnerships in Wisconsin between integrated delivery systems and small group practices can create a culture of learning and fostering of best practices to improve quality of care and reduce costs. This effort also helps small groups and solo practices that wish to maintain their independence from a larger system, such as Aurora, the ability to do so. By clinically integrating with other providers, we have the ability to collaborate on key aspects of patient care and avoid consolidations that are made out of financial necessity. Even with this support, however, practices in small and rural communities will need additional support and flexibility to successfully transition away from the fee-for-service to new payment and delivery models.

In addition, Aurora Health Care is currently participating in the Comprehensive Care for Joint Replacement Payment Model, Medicare's first mandatory bundled payment program. We hope to stay in close contact with CMS and other stakeholders to share our experiences on this initiative to ensure that a culture of continuous improvement informs our way forward on this important initiative.

- **How can CMS be the most helpful in making MACRA implementation successful and ensuring adequate stakeholder engagement occurs?**

MACRA envisions a system of care that spans facilities and provider types and is focused on the aggregate quality of care that the patient receives. In short, it facilitates breaking down many of the silos that have dominated healthcare for too long. While CMS has introduced a number of risk-based initiatives, the agency is still internally structured for and regulates by silos of care based on setting. Furthering the effort to reduce compartmentalization in the healthcare delivery system must be accomplished to accelerate MACRA's success but may be hindered until the regulatory environment and CMS' organizational structure evolves further.

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